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The Illinois Medical Journal

The Official Journal of

The Illinois State Medical Society



Index to Volume 119
January-June, 1961

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Published monthly by the Illinois State Medical Society, 360 N. Michigan Avenue, Chicago 1, Ill. Subscription $4.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, Hawaiian Islands, and Mexico. $6.00 per year for all foreign countries included in the postal union. Canada, $4.50. Single current copies 50 cents. By mail, 60 cents.

Entered as Second Class Matter Nov. 12, 1952, at the Post Office, Mendota, Illinois, under the Act of March 8, 1879.

Acceptance for mailing at special rate of postage provided for in section 1102, Act of Oct. 8, 1917, authorized July 15, 1918.

POSTMASTER: Send notices on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago 1, Ill.

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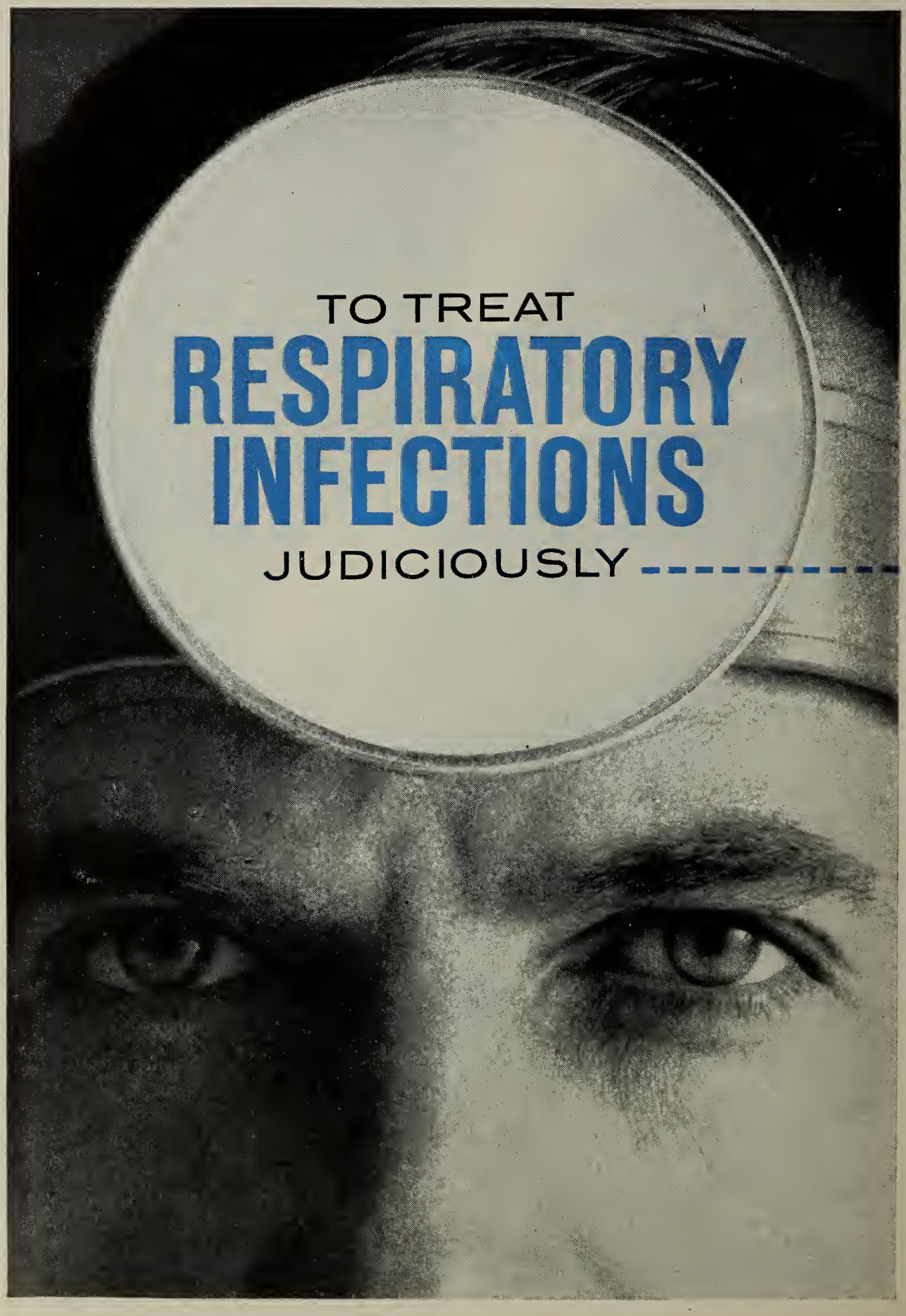
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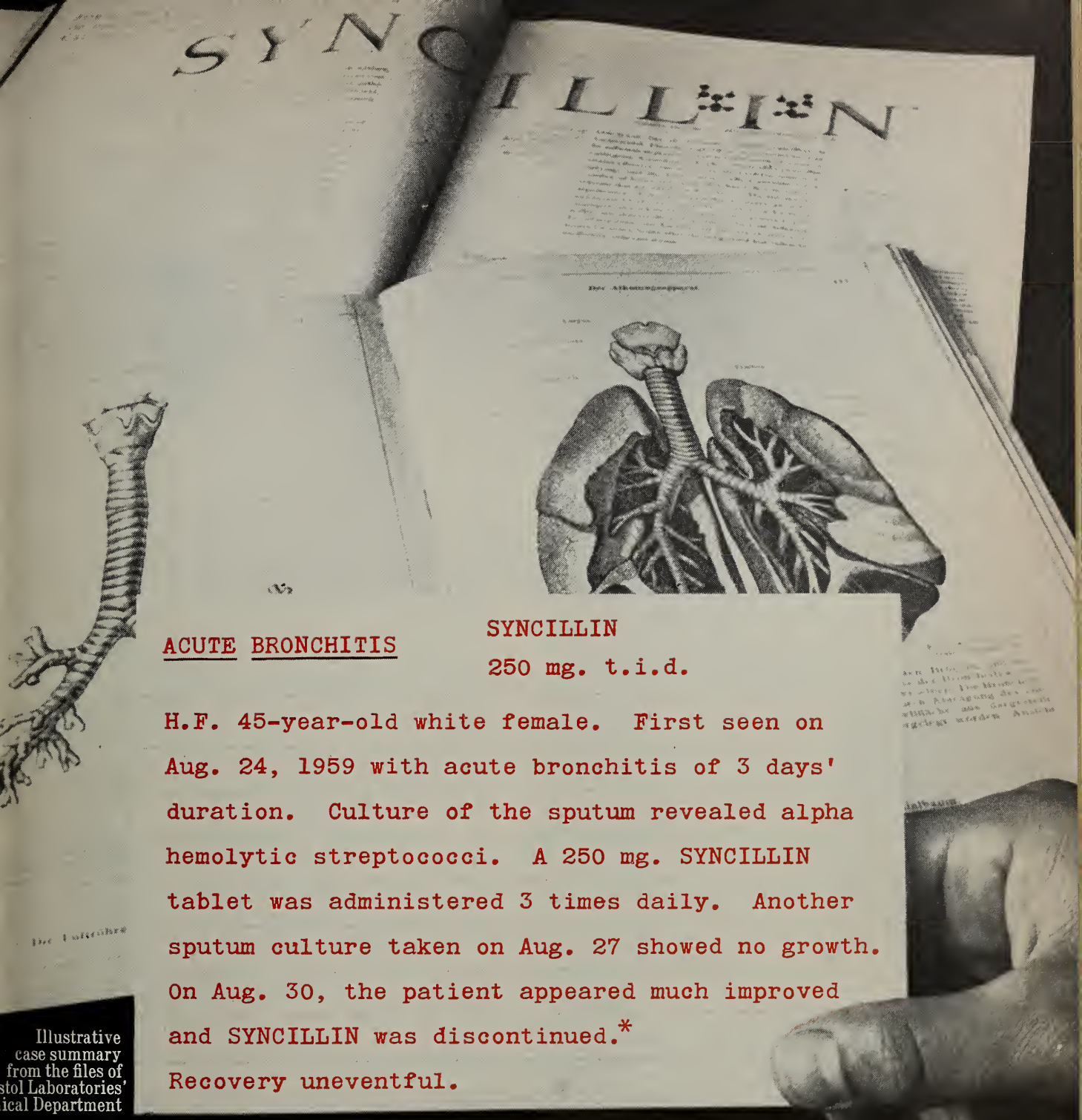
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Physicians are being urged to cooperate fully to get their states to participate as soon as possible in the new federal-state program for medical care of needy and the near-needy older persons.

The medical profession also has been alerted to the dangers of relaxing its opposition to tying in medical care of the aged with social security. It is probable that the Kennedy administration will try in 1961 to get Congressional approval of such legislation.

E. Vincent Askey, M.D., president of the American Medical Association, pointed out to the recent Washington meeting of the A.M.A. House of Delegates that proponents of the social security approach had a pledge of support from the successful Democratic candidate for president.

"While our profession clearly may face a hard struggle in the 87th Congress on the issue of medical aid for the aged under social security, there is no ground for defeatism!" Dr. Askey said. "Our cause is far from lost. We know that our policy position is in the best interests of all Americans, the aged included, and our willingness to defend this policy must be strengthened and maintained." He reminded the House of Delegates that "medicine has many friends in both parties in Congress today."

A few days later, Sen. Harry F. Byrd (D., Va.), chairman of the Senate Finance Committee, which handles Social Security legislation, reiterated his opposition to a compulsory medical care plan under social security. He said, "I am opposed to the (Democratic party) platform recommendation for compulsory medical service and hospitalization under the social security system. I am convinced this would lead to socialized medicine with the possibility that it would bankrupt the social security trust fund. This matter came before the Finance Committee and was fought out in the post-convention session of Congress last August. The Senate voted 51 to 44 in opposition to the Democratic platform proposal, and instead adopted a fair plan for medical service and hospitalization for those in need of it."

Dr. Askey urged that all county and state medical associations provide "the medical leadership necessary to implement the Mills-Kerr Bill (the new federal-state program) as rapidly as possible." And the House of Delegates adopted such a resolution. "We must put forth a sincere and concentrated effort during the coming year to make the Mills-Kerr law effective, to show that it can, practically as well as potentially, solve the problem of medical care for the aged," he said.

President-elect John F. Kennedy's first Cabinet appointment was Gov. Abraham Ribicoff of Connecticut as Secretary of Health, Education and Welfare — the official with primary responsibility for carrying out the federal part of the Mills-Kerr program.

Ribicoff, 50, was an early supporter of Kennedy for the Presidential nomination. He was twice elected governor of Connecticut. Before that, he served as a Hartford, Conn. police judge, a member of the state legislature, and a member of the national House of Representatives. As governor, he inaugurated a comprehensive traffic safety program with strong penalties.

The Sabin oral polio vaccine will not be available in sufficient quantity in 1961 for large scale use. Leroy E. Burney, M.D., Surgeon General of the U.S. Public Health Service, told the recent Clinical Meeting of the A.M.A. that many problems involved in taking the oral vaccine out of the laboratory and into mass production had not been solved.

In light of this fact, both the A.M.A. House of Delegates and Dr. Burney urged that the widest possible use of the Salk vaccine be encouraged. Dr. Burney said that large numbers of the U.S. population, including almost half of the children under five, had not been fully vaccinated with the effective Salk vaccine.

Dr. Burney said the problems of integrating the oral vaccine into the present program of immunization

(*Continued on page 29*)

WASHINGTON (Continued)

against polio "are many and complex. Only the future can tell whether control of poliomyelitis will be accomplished through a live, orally administered vaccine, the killed vaccine, or a combination of both," he said.

The Food and Drug Administration issued stricter rules, some effective January 8 and others effective March 9, governing promotion and marketing of prescription drugs. The new regulations are designed to insure safe use of the drugs.

Under the new regulations manufacturers must disclose hazards, as well as advantages, of the drugs in promotional material sent to physicians. Manufacturers can be denied permission to market drugs if they refuse to permit FDA inspection of manufacturing methods, facilities, controls or records.

The FDA deferred until later action on its proposal to require every package of drugs sold to pharmacies to contain an official brochure on their use and hazards. The AMA proposed instead that it be given the responsibility of getting such information directly to physicians.

Foreign interns who failed medical examinations last September may remain in this country until at least next July 1.

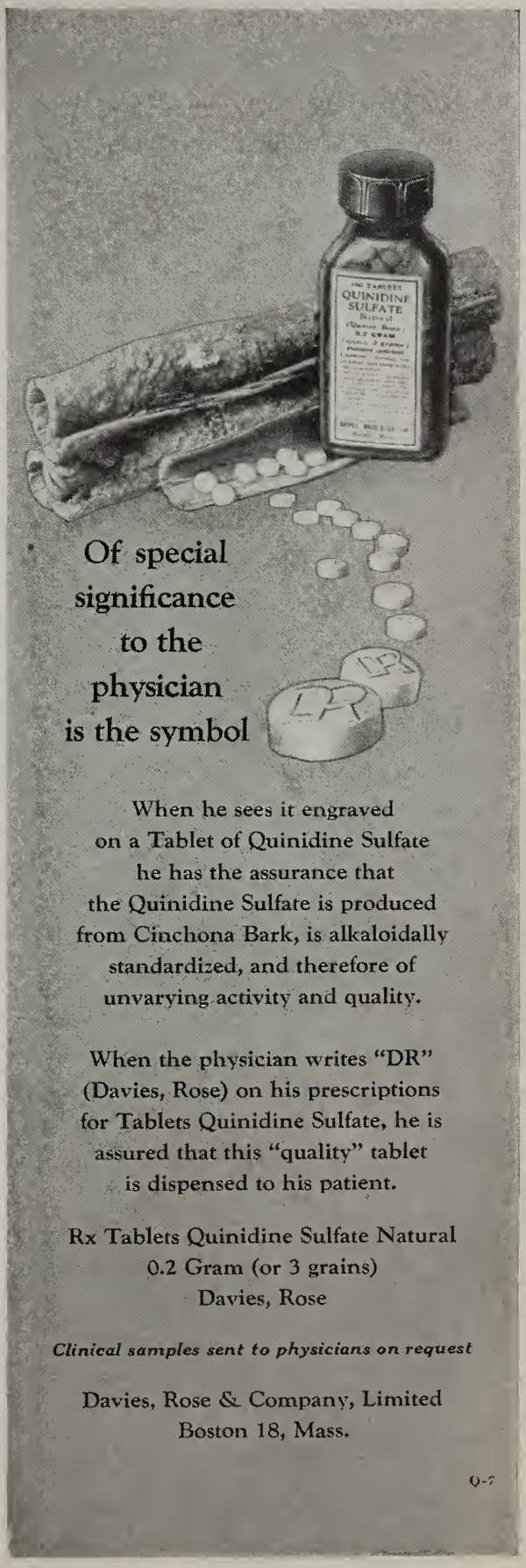
In cooperation with the State Department, the AMA agreed to extend for six months a Jan. 1 deadline for dismissal of foreign interns unless they pass the examinations through the Educational Council for Foreign Medical Graduates.

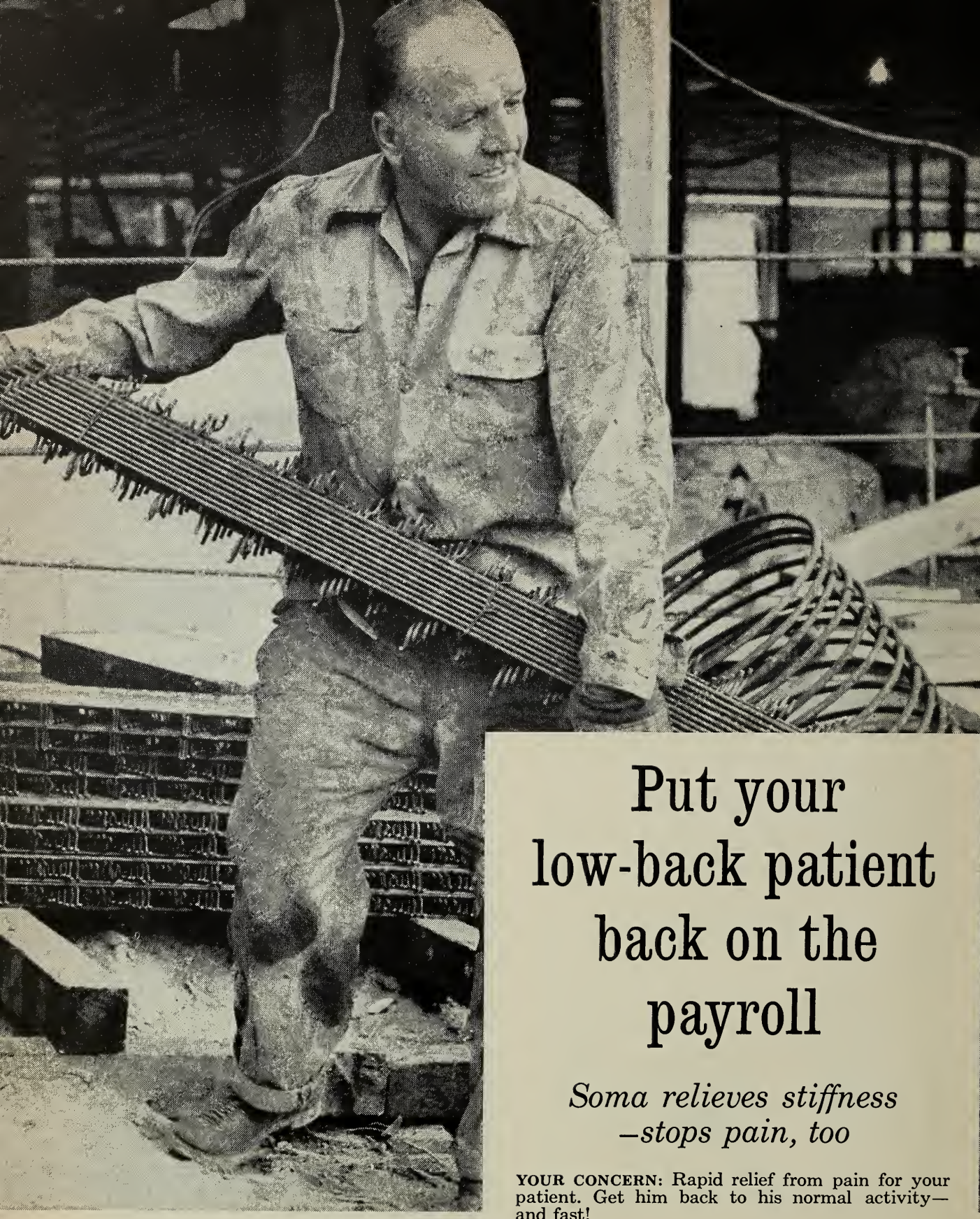
The flunking interns will be given another opportunity to take the examinations in April. Meantime, they must be taken off patient care, and their hospitals must set up training programs for them.

The AMA Council on Medical Education and Hospitals, said that this policy would be carried out judiciously and that occasional exceptions would be granted where circumstances warranted.



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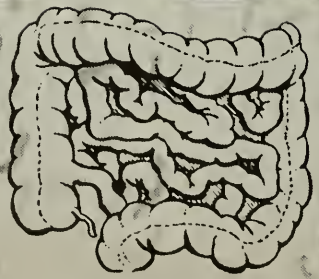
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Wrecking our own plans

Admittedly there is abroad in the land a socialistic attempt to have everybody cared for medically on a paternalistic Federal plan whose full fruition would only mean universal mediocre medical care at a prodigious cost to the taxpayer. In combating this movement we have fostered third-party medical care plans of our own on insurance principles with which the vast American working population is familiar. It has been our hope that gradually these plans could be developed to the point that they would cover practically all medical contingencies while at the same time safe-guarding the right of free choice of physician and guaranteeing freedom from bureaucratic control. The effort has been well received and the operation of the plans has been in the main satisfactory on the nationwide level. But latterly the cost of these services to the subscribers has been rising at a rate which seems disproportionate to the rise of some other costs. And one is forced to suspect that a part of this rise at least is due to abuses by some of the very medical personnel who are leaders in the opposition to legislatively imposed schemes.

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What I am referring to principally is the hospitalization of patients, for diagnostic or therapeutic studies of trivial conditions, who would not otherwise, save for their prepaid participation in the plans, be considered for such studies. Ill-considered and irresponsible practice of this sort can lead to as much abuse of a good principle as we see in the present operation of the compensation laws, in which the employer has now been made responsible for almost all illness, through willingness of some physicians to bear false witness. Our answer, through insurance, to the public's desire for third-party medical expense coverage can be wrecked by such unprincipled action, for the cost of the unnecessary care of some subscribers to the plan is prorated in the charges to all. *Harry Beckman, M.D. Abuse of Third-Party Medical Care. Wisconsin Med. J. September, 1960.*

Thought is, perhaps, the forerunner and even the mother of ideas, and ideas are the most powerful and the most useful things in the world.

—*George Gardner*

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The
ILLINOIS
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Official Journal of The Illinois State Medical Society

JANUARY, 1961
VOL. 119, No. 1

Dicumarol,® Diet and Drugs

Richard J. Jones, M.D., *Chicago*

The virtue of long-term anticoagulant therapy after an acute myocardial infarction is becoming more firmly established. In a recent review of a 10-year experience with such therapy at the University of Chicago involving 166 patients followed two years from the date of their infarction on continuous Dicumarol® therapy and 270 patients not so treated, it was found that the two year mortality rate in the treated group was only 13 per cent as compared to 26 per cent in the control group. On further analysis of these two groups, it was found that the benefit was more substantial in patients who had suffered more than one myocardial infarction but was still highly significant even after the first myocardial infarction. The benefit derived was due to a reduction in thromboembolic episodes and in attacks of "sudden death."

These figures considered only grossly whether the patient was in the treated or control group. All treated patients were taking a prothrombin-depressing drug under careful laboratory control, though occasionally the prothrombin time would fall outside of the therapeutic range of 1.75 to 2.5 times the control one-stage (Quick) prothrombin time. Records of patients on anticoagulant therapy who did have recurrent myocardial infarction were examined in detail; in 18 cases a prothrombin time was recorded within two days of onset of myocardial infarction. In exactly half of these cases, the prothrombin time was below the lower limit of the therapeutic range; hence the objective of the therapy was not being fully realized. This fact suggested that an even greater than 50 per cent reduction in mortality and recurrent myocardial infarction rates might evolve with the development of a more easily and consistently regulated anti-

From the department of medicine, University of Chicago.

While the Nutrition Committee of the Chicago Heart Association is sponsoring this article, the opinions expressed are those of the author and do not necessarily represent the official view of the committee.

coagulant regimen. With long-term Dicumarol anticoagulation for prevention of myocardial infarction, our partial success is not unlike the early success of sulfanilamide in the treatment of pneumonia. It is quite possible that we may see ultimate improvement in anticoagulant therapy comparable to that witnessed in the antibiotic field. Until that day comes, however, it might be worthwhile to review the factors which influence the manipulation of the prothrombin level by coumarin and indandione derivatives.

Influencing factors

The level of prothrombin in the serum is maintained by its enzymatic synthesis in the liver which requires the presence of vitamin K. Dicumarol, which is structurally similar to the K vitamins, suppresses this synthesis by competitive inhibition.[2] Vitamin K is not stored in the body in large quantity but is constantly manufactured from ingested vegetable compounds by intestinal bacteria. Vitamin K deficiency is seldom encountered after the infant develops an intestinal flora. The only exceptions occur in certain diarrheal states, such as celiac disease, biliary obstruction when absorption of this fat soluble vitamin is impaired, and in hepatic disease when the synthesis of prothrombin is modified. Thus, while the available vitamin K may play some role in determining sensitivity of the individual to Dicumarol administration, the dietary intake is probably not closely related to the ease with which this prothrombinopenic effect may be regulated. More important perhaps are nutritional and medicinal factors that exert great influence on this unique aspect of liver metabolism.

Though dietary experiments in the rat have suggested no particular alteration in susceptibility to Dicumarol with dietary supplements of fat, vitamin C, choline, or casein[3], a clinical impression has persisted that patients with cachexia and protein deficiency were uniquely susceptible to the prothrombinopenic effect of Dicumarol.[2,4] In fact, Dr. Irving Wright has suggested that such patients might benefit from the daily ingestion of one quart of milk[4]. One of the leading causes for such a deficiency, of course, is chronic alcoholism, and it is felt that this may sometimes explain undue sensitivity to Dicumarol. Practical experience suggests that Dicumarol dosage regulation in some patients may be influenced by a different effect of alcohol for, in them, one or two cocktails prior to the evening meal can enhance the Dicumarol effect. A similar ease of prothrombin regulation seems to be achieved in such patients, whether they abstain completely or consume equal daily rations of an alcoholic beverage. This clinical impression has support in one old and incompletely reported series of experiments in rats that were shown to develop a greater increase in prothrombin time with daily alcohol and salicylate dosages combined than with either drug alone[5].

Certain common medications must also be considered in maintaining a stable anticoagulant effect. Salicylates have a mild prothrombinopenic effect of their own, even in the absence of coumarin derivates;[4,5] certain antibiotics such as the tetracycline derivatives, by modifying the intestinal flora, interfere with vitamin K synthesis in the gut, thus influencing the control of prothrombin level by Dicumarol[4]; and a recent abstract has suggested that large doses of barbiturates may have a significant effect on the prothrombin level by impairing biscoumacetate inhibition of prothrombin formation.[6] This latter is antithetical to the observations that the prothrombin time is prolonged by acute fright, by experimental fever, and by hyperthyroid and other hypermetabolic states.[5] Clinical experience would suggest that in most subjects of Dicumarol therapy, it is these factors of vitamin K availability and sedation on the one hand and emotional disturbance, intercurrent fever, hypermetabolism, medication, or alcoholic beverages on the other, which must be balanced for optimal stability in prothrombin time regulation.

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Management of Skin Cancer by the Dermatologist

J. M. McCuskey, M. D., *Peoria*

The purpose of this presentation is fourfold: (1) to discuss the need of dermatologic training in the diagnosis and management of most skin cancers; (2) to briefly discuss the various treatments commonly used to treat cutaneous malignancies; (3) to show what disposition was made of or treatment given to patients in a private dermatologic practice over a two-year period with a statistical survey of the cancers seen, and (4) to evaluate the results of treatment by the dermatologist and show the five-year cure rate with emphasis on the most commonly used method of treatment, electrodesiccation and curettage, followed by x-ray therapy.

Diagnostic considerations

The diagnosis of a typical basal or squamous cell epithelioma is often not a difficult matter for most physicians. But frequently the diagnosis is not an easy matter even for physicians with dermatologic training. It is not always easy to determine when a nevus or seborrheic or senile keratosis is becoming malignant. Granuloma pyogenicum frequently resembles an epithelioma, and vice versa. There are few physicians without special training or experience that recognize Bowen's disease, multiple superficial epithelioma, extramammary Paget's disease or morphea-like epithelioma.[1] Patients now go to their physicians often because of their fear of cancer and because they have read or have been told that an early diagnosis is important to obtain a cure. These early lesions are especially difficult to diagnose. A biopsy can be obtained by any physician without special training; but if a representative portion of proper depth is not secured, the information obtained may be entirely misleading. Since errors can be made in interpreting results, even by pathologists with considerable experience, the physician should be able to correlate the clinical appearance and histopathologic picture to establish the proper diagnosis. An erroneous biopsy report may result in treatment of a nonmalignant lesion for cancer, and conversely, a cancer may go untreated if the clinical and histopathologic information are not properly correlated. There was one instance in this series in which the section for microscopic examination did not reveal a typical epithelioma in a repeat biopsy specimen. Expert pathologists sometimes disagree on the diagnosis. This is especially true of malignant melanoma. So here again, the proper clinical impression is of utmost importance and may determine the final diagnosis. These facts merely illustrate what every dermatologist knows — that while the diagnosis is frequently not difficult, there are many instances in which considerable judgment, training, and skill are required to avoid errors.

Some knowledge of the type of skin of the patient who is to receive x-ray or radium therapy is important. Almost everyone giving this type of treatment is aware that a senile, atrophic, or fair skin will not tolerate the amount of radiation therapy that can safely be used on a normal skin, but other conditions such as xeroderma pigmentosum may not be recognized. For the past few years I have observed two patients with the latter condition. Each has had several basal and squamous cell epitheliomas, but one has a large skin graft on one cheek necessitated by the removal of an area of radiodermatitis following treatment of a skin cancer treated elsewhere with a dosage of x-ray that probably would not have been excessive for a normal skin.

Types of treatment

No attempt is made here to describe in any detail the several methods used to treat cutaneous malignancies, any of which may be good. Obviously the best method is the one most likely

Chairman's address, Section on Dermatology, Illinois State Medical Society Annual Meeting, May 1960, Chicago.

to produce a cure with the best cosmetic result and the least discomfort, inconvenience, and expense to the patient. It is very important however, to know what method or methods should be employed and to be trained and equipped to use the best one for the particular cancer being treated. If the physician does not have such training, experience, and equipment, the patient should be referred to someone who does. Since few physicians possess all these essentials, almost everyone treating cutaneous malignancies will have occasion to refer patients.

1. *X-ray and radium therapy.* Radiation therapy, especially x-ray therapy, is probably the most commonly used treatment for epitheliomas. MacKee, Andrews[2], Cipollaro[3], Eller[4], and many others have written extensively on these methods, and Lehmann and Pipkin[5], John Lain, and others, regarding the use of radium treatment. The most generally accepted method of administering x-ray therapy during the past 15 years is by the divided dose technique in which a total of from 4000 to 8000 or even 9000 r units of x-ray are given in divided doses of six or eight treatments over a period of two or three weeks. It is my impression that more epitheliomas are treated by x-ray alone, especially by the younger physicians, since the beryllium window in superficial radiation therapy and the increased use of the fractional method of treatment became popular.[6]

2. *Electrodesiccation and curettage.* This method is often followed by x-ray therapy. I feel that a fairly high percentage of cures can be obtained by the proper use of this method alone. Recently Ferrara[7] reported 94.9 per cent five-year cures of 82 epitheliomas treated by this method alone. Morrow, Miller, and Taussig[8] in 1937 reported the cure of 66 of 88 patients with epithelioma of the lip treated in this manner, but the patients were followed from only 6 months to 5 years. While this method is seldom used now for treatment of epithelioma of the lip, a substantial number can be cured by it.

3. *Electrodesiccation and curettage followed by x-ray therapy.* This method has been employed by many dermatologists for years and has proven highly successful. The combined method has much to recommend it. The operator employing the curette can easily, because of the usual softness of the cancer tissue, follow the pockets that often extend laterally and below the otherwise visible cancer. Then when shielding the area for x-ray treatment, every portion of the area occupied by the cancer should be included. Also a much smaller dose of x-ray is needed, and there is no evidence of x-ray damage occasionally seen several years later when the larger doses of 6000 r to 8000 r are used. Lesions over 3 or 4 cm. in diameter in certain areas and in certain types of skin will not tolerate these higher doses without some subsequent visible evidence of x-ray damage. Often doses of 1750 r to 2800 r units are sufficient if given following preliminary electrodesiccation and curettage. The cosmetic result is usually very good. There is no higher percentage of five-year cures than the 97.1 per cent obtained by Elliott and Welton[9] in their series of 1,052 patients with this method.

4. *Surgery.* Many epitheliomas can be cured by surgical removal.[10] The smaller ones can be removed by any physician with some surgical training and knowledge of skin cancer, but larger lesions and those in certain locations are best treated by an experienced surgeon. If extensive repair is needed, a plastic surgeon will offer the best chance of cure and the best cosmetic result.

5. *Chemosurgery.* Mohs,[11,12] later modified by Lunsford et al.,[13] has developed a technique of treatment of accessable epitheliomas and melanomas by means of the application of a cauterant zinc chloride paste. The tumor is gradually removed and successive layers are examined microscopically for the presence of tumor cells. This treatment requires considerable skill and a team equipped and trained to do it. It is a method that probably is one of choice for larger epitheliomas, those that have recurred and are surrounded by scar tissue, or those in certain locations that cannot be adequately treated in more conventional ways. It is not likely that this method is the one of choice for more than 2 or 3 per cent of all epitheliomas, but it is valuable for an occasional lesion.

Management of cutaneous malignancies

It may be of interest to examine the records of patients with skin cancer seen in a private practice to know what was done for them, what treatment was given, the results of treatment, and if not treated what was advised. The record of each patient with cutaneous malignancy in

sequential order seen by me during 1953 and 1954 was examined. Obviously they were the last ones from which the results of a five-year cure could be obtained. One hundred thirty patients with various types of skin cancer were seen. Some had multiple lesions and a few returned during the period with additional epitheliomas to make a total of 157 cancers observed. Twenty four of the 130 patients representing 27 epitheliomas and 2 melanomas were not followed for five years. Eleven had died from other causes. We were unable to locate 13 patients. Although none showed any evidence of recurrence, they were not included in the statistics. A biopsy specimen was obtained from 133 of the 157 lesions. Of the 24 in which no biopsy was obtained 15 occurred in 3 patients. Many lesions were small, and a biopsy was not obtained for various reasons, often because of the extra expense involved.

Seven patients were referred elsewhere for treatment. A 43 year old woman with a basal cell epithelioma on her cheek who gave a history of having had the lesion surgically removed and a recurrence treated by radium was referred to a plastic surgeon. A 22 year old woman with a basal cell lesion on her cheek that had recurred following surgical excision on two occasions and again following x-ray therapy was referred to a plastic surgeon. An 85 year old woman with a large squamous cell epithelioma of the thumb, adjacent palm, and forefinger occurring in a radiodermatitis incurred following treatment for eczema by her family physician was referred to a surgeon for amputation of thumb, forefinger, and adjacent hand. A five-year cure was obtained in these three patients. A 36 year old man who had been treated for 4 epitheliomas, both basal and squamous, on his nose and cheek was referred to a plastic surgeon when he developed another. A large area of the nose and left cheek was excised and skin grafted. Two years later another developed near the border of the skin graft, and this was excised and grafted. A 75 year old man with a large squamous cell epithelioma almost encircling the left middle finger was referred to a surgeon for amputation of the finger. There was no evidence of recurrence two years later when he died of a heart attack. An 88 year old woman with a malignant melanoma 4 cm. in diameter on her cheek and an 85 year old woman with a malignant melanoma on her great toe were referred to surgeons. The melanoma of the cheek was excised and the toe amputated. Both were lost from observation.

No other patients were referred. Except for 3 patients, all were treated by electrodesiccation and curettage followed by x-ray therapy. A squamous cell epithelioma was treated with radium needles used interstitially; a basal cell lesion on the bulb of the nose was treated with x-ray alone, and a squamous cell epithelioma of the scalp was treated with electrodesiccation alone. All had five-year cures. The amount of x-ray therapy given following the preliminary electrodesiccation and curettage varied from 1400 r to 2800 r units, the majority receiving 1750 r units (5 Ma, 100 KV, half value layer 1 mm. aluminum.)

X-ray therapy was given in divided doses in all except two patients for whom the entire treatment of 1400 r units was given in a single visit. The present practice is to give a total of 2800 r units (350r units twice every week) usually beginning immediately following preliminary electrodesiccation and curettage. If there is uncertainty regarding the diagnosis, x-ray therapy is delayed until the biopsy report is obtained. Lesions larger than 3 cm. in diameter receive proportionally smaller doses. A margin of 2 or 3 mm. of apparently normal skin surrounding the site of the epithelioma is desiccated, and a similar margin beyond the desiccated border is included in the area treated by x-ray.

Results show that 123 epitheliomas were treated with electrodesiccation and curettage followed by x-ray therapy. All were followed for 5 years or longer. One hundred twenty or 97.6 per cent were cured.

There were 3 failures. Two of these subsequently obtained five-year cures, one by retreatment with electrodesiccation and curettage followed by 1750 r units x-ray. The other was an epithelioma of the lip that was apparently radio-resistant as both electrodesiccation and curettage followed by x-ray therapy, and later radium used interstitially, failed to cure it. He was referred for surgical excision and obtained a five-year cure. The third failure was a rather large ulcerated basal cell epithelioma near the external auditory canal of a 46 year old man. This lesion was treated by electrodesiccation and curettage followed by x-ray therapy during September, 1954. It recurred and the patient consulted a plastic

surgeon who excised it in November, 1957. A subsequent recurrence was again surgically excised in March, 1960. It is possible that this is an instance in which Moh's technique would have been the treatment of choice.

Of the 157 lesions observed the types were as follows: basal cell 117, squamous cell 33, mixed 2, intraepidermal 3, malanoma 2.

Further statistics regarding the size of the lesions, age, sex, duration, previous treatment and location are not given here since they are comparable to those included in other articles published on this subject and since these statistics are not the primary purpose of this presentation.

Summary

The diagnostic considerations for the proper management of cutaneous malignancies are discussed. A brief discussion is given of the various types of treatment used. Selection of the proper type of treatment for the particular malignancy is necessary to obtain the best possible therapeutic and cosmetic result.

An analysis of 130 patients with 157 skin cancers seen in sequential order during a two-year period is presented. Seven patients were referred elsewhere for treatment and 3 were treated respectively with radium, x-ray alone, and electrodesiccation and curettage alone. Twenty-four of these patients representing 27 cancers were not followed for 5 years and were not included since they either died from other causes or could not be located. The remaining 120 lesions in patients who were followed for 5 years or longer, were treated with electrodesiccation and curettage followed by x-ray therapy with 97.6 per cent cures. Two of the failures subsequently obtained a 5-year cure, and the other is currently under treatment. Of all the 157 cancers treated by one or more of the various methods described, this is the only one that is known to have not yet obtained a 5-year cure.

The advantages of the method of combined therapy in addition to the satisfactory five-year cure rate are discussed. It is felt that this method is highly satisfactory and should be the treatment of choice for a large majority of epitheliomas.

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Pediatric practice

Before 1920 the pediatrician was primarily a consultant; subsequently he became a physician for a number of children in a general way, as well as doing a certain amount of consultation. In the last few years the average practicing pediatrician has not seen many children in direct consultation with other physicians. He has become more and more a generalist, unless he is connected with a university center or practices some form of subspecialty. Because of this there has been a tendency for the pediatrician himself, as well as the general practitioner, to refer patients with special problems to system specialists or specially trained pediatricians who might be termed superspecialists, such as the pediatric allergist. *Robert B. Lawson. Historical Perspective of Pediatrics in the United States. Careers in Pediatrics. 1960.*

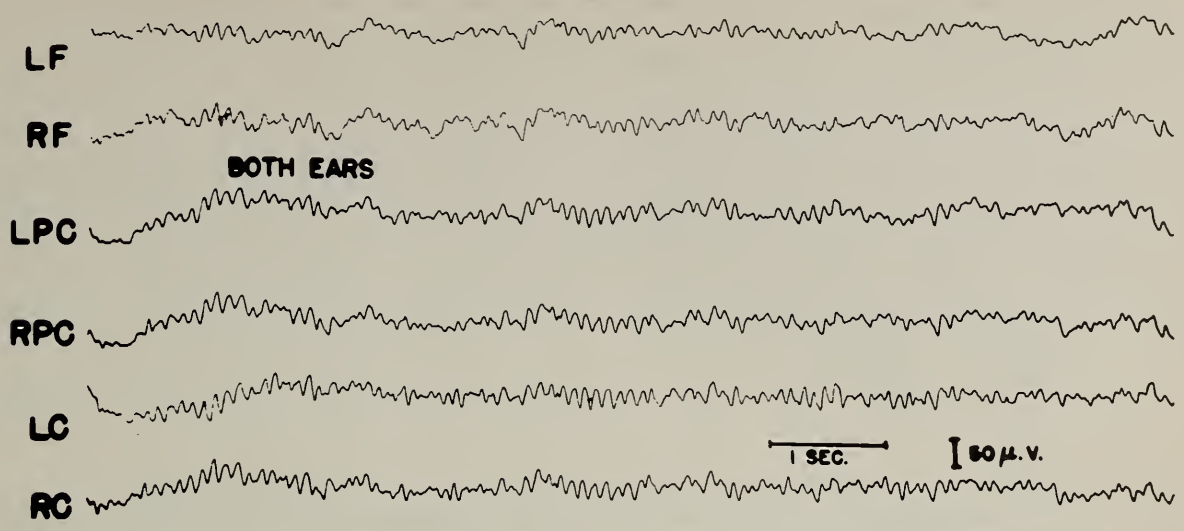


Figure 1. EEG control study, using 60 mg. of Nisentil alone (in divided doses similar to supplementation of nitrous oxide), shows a normal wake pattern.

Electroencephalographic Sleep Patterns In General Anesthesia

Max S. Sadove, M.D., C. G. Yarbrough, M.D., and Dorothy R. Becka, *Chicago*

We have found the short and rapid properties of Nisentil®,* in combination with nitrous oxide, to be especially valuable in cases where an intravenous narcotic anesthetic agent must be administered during a prolonged operation. The cumulative and circulatory effects are minimal, the anesthetic plane is adequate, good relaxation is obtained by appropriate curarization, and recovery of consciousness is prompt.

An electroencephalographic control study was done, using 60 mg. of Nisentil alone (in divided doses similar to that used in the supplementation of nitrous oxide), and a normal wake electroencephalogram was obtained (Figure 1). At the end of the study, the subjective sensation was grogginess.

Many continuous electroencephalograms were taken during surgery using nitrous oxide as the primary anesthetic agent, and a low voltage fast (15 to 25 per second) activity invariably was noted (Figure 2). This correlates with the findings of Wyke,[1] Courtin et al.,[2] and Artusio.[3] Patients were maintained at this level of analgesia for the entire operative procedures.

Anesthesia for the cases in this study was accomplished with an induction of thiopentone and maintenance with Nisentil and nitrous oxide. Nisentil was given intravenously in two twelve mg. doses; one immediately after induction, the second in 20 minutes. Six mg. doses were given at 20 to 30 minute intervals until 42 mg. were given, and then 3 to 6 mg. doses only as needed to completion of the operation. During the operative procedure the inhalation mixture was 3L:1L nitrous oxide-oxygen. Where excellent relaxation was desired, succinylcholine or some curaremimetic agent was administered in-

**Nisentil — alphaprodine hydrochloride (dl-alpha-l, 3,-dimethyl-4-phenyl-4-propionoxy-piperidine-hydrochloride). Provided for this study by Dr. M. J. Schiffrin, Hoffmann-LaRoche, Inc.*

From the VA Hospital, Hines, Illinois, and the West Side VA Hospital, Chicago.

travenously as an adjunct to the Nisentil-nitrous oxide-oxygen anesthesia.

The combination of Nisentil-nitrous oxide-oxygen was used as continuous electroencephalograms were taken on eight patients. These electroencephalograms showed patterns not unlike those seen during routine sleep recordings. The tracings showed flat patterns with parietal humping (drowsy stage), well formed 14 per second sleep spindles (light sleep stage), and irregular slow patterns with some spindle formation (deeper stages of sleep) (Figure 3).

Figure 4 shows the anesthesia or sleep electroencephalographic pattern at the end of surgery. Clinically this patient was more than asleep. He was at least in plane I anesthesia and did not respond to the spoken word, react to painful or surgical stimuli, or resist passive movement of parts of his body. However, when the mask was removed, and the patient was permitted to breath room air, within 10 seconds the electroencephalogram showed the type of activity characteristic of the waking state, 10 per second waves. Immediately the patient opened his eyes



Figure 2. Low voltage 15 to 25 per second activity with nitrous oxide the primary anesthetic agent.

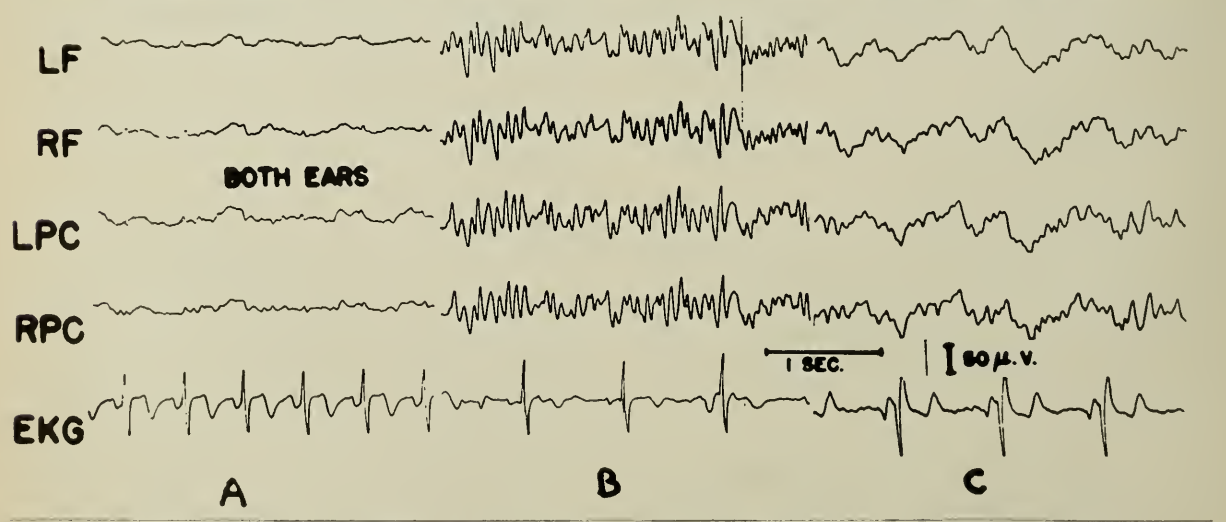


Figure 3. A combination of Nisentil and nitrous oxide produced patterns resembling (A) drowsy, (B) sleep spindles, (C) deeper stages of sleep.



Figure 4. (A) shows the anesthesia or sleep EEG pattern. (B) shows the return to a normal wake pattern 10 seconds after patient was permitted to breath room air. Continuous recording except at slash when 3 seconds were omitted due to artifact when mask was removed.

and responded to simple verbal commands and was oriented to name and date. This would be in keeping with Lancaster and Levin findings.

Forty-seven per cent of their patients were aroused in the operating room and the other 53 per cent, within a half hour after having recovered their laryngopharyngeal reflexes.

A notable feature in this anesthetic procedure was the residual analgesic effect that produced a reduction of restlessness and discomfort of the immediate postoperative period.

Discussion

Again we see that a specific agent has a specific pattern. Obviously, when the electroencephalogram is used, we must know the agent being utilized or the depth of anesthesia cannot be judged.

It also becomes obvious that we have a pattern resembling the electroencephalographic pattern for natural or deep sleep, and yet surgical procedures can be done under this state. The clinical signs are such that we cannot distinguish between the sleep pattern seen on the electroencephalogram and the surgical anesthesia perceived on examining the patient. In a few instances, the electroencephalogram shows this light sleep state and, without warning, there is a movement indicating that the patient has slipped out of the surgical anesthesia plane. It is possible that we are working, in reality, in the analgesic plane.

The electroencephalogram is an excellent indicator for such things as hypoxia, marked hypotension, extreme depth of anesthesia, and the planes of anesthesia. However, in some instances, we have been unable to distinguish between the plane of movement on the electroencephalogram and the plane in which the patient does not respond to painful stimuli, which may represent the analgesic plane.

Summary and conclusion

1. A combination of Nisentil and nitrous oxide produced an electroencephalographic pattern resembling drowsiness and sleep although clinically the patients were in plane I anesthesia. Nitrous oxide alone produces a fast pattern in the electroencephalogram, and Nisentil alone does not alter the normal waking pattern.
2. Arousal of patients in the operating room after prolonged Nisentil and nitrous oxide anesthesia was astonishingly prompt, very similar to awakening a person from a normal sleep.

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Clinical-Surgical Conferences



Cook County Hospital

Postoperative Hemorrhagic Diatheses

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Dr. Robert J. Baker: The conference today deals with a grave complication of surgery or of blood replacement during surgery that is of considerable moment to all of us. Massive, unexpected bleeding is to the surgeon what a sudden cardiovascular catastrophe is to the internist, and with similar life-endangering implications.

A primary factor in the production of these coagulation defects is the administration of large volumes of blood. Banked blood, despite all tests which we perform and all our efforts to preserve it as a whole replacement substance, is not identical with the patient's circulating blood, and virtual exchange replacement, as may occur, leads on occasion to some of the alarming phenomena that will be discussed.

Our speaker today is Dr. Irving Friedman of the department of hematology. He is well known to all of us, having been of inestimable help in the coagulation problems we have had to face from time to time. There is no one as close to our problems and no one better able to build a concrete diagnostic framework from which to work than is Dr. Friedman. The first case is illustrative of the type of problem we experience in this hospital, and we will ask Dr. Snyder to present it.

Case 1

Dr. Dayle O. Snyder, surgical resident: This patient was a 52 year old white male, admitted to the surgical service of the Cook County Hospital with a six weeks' history of epigastric burning one to two hours after meals and at night. For two weeks prior to admission he had vomited most ingested food. Pain was relieved by soda but vomiting was not. He stated that he was sensitive to penicillin but nothing else in the past history was remarkable.

Physical examination revealed a moderately dehydrated, agitated man with marked epigastric and right upper quadrant tenderness. Three thousand cc. of clear fluid containing old food particles were obtained by Levine suction. The patient improved symptomatically. After eight hours of suction, the tenderness returned, and a perforated duodenal ulcer was closed uneventfully, though 2 units of blood and 1 unit of plasma were infused before and during surgery. The patient was type A, Rh negative.

During the next two weeks the patient commenced to bleed from the upper gastrointestinal tract, developed pneumonia in the right lower lobe, and was infused with 4 more units of whole blood. He bled sporadically for two weeks, was intermittently transfused, and developed a partial small bowel obstruction which subsided.

During the subsequent two weeks the patient alternately had bouts of small bowel obstruction and bled from the duodenum. Some 11 weeks after admission he suffered a major hemorrhage, necessitating gastric resection, which was per-

formed under local anesthesia. During surgery the patient was given 2 units of A, Rh negative blood followed by 2 units of A, Rh positive blood. He tolerated the procedure fairly well, but considerable wound oozing was noted during closure. Two hours postoperatively the patient went into profound shock, commenced to bleed from the upper and lower gastrointestinal tract, as well as wound and drain sites, and despite all resuscitative measures, died some 24 hours after surgery.

Dr. Baker: I was intimately involved with this patient, not from the standpoint of surgery but from the standpoint of postoperative management. There are several things I would like to point out with regard to the postoperative course. In the 11 weeks this man received 26 units of whole blood. All of these, with one exception, were A, Rh negative, the one exception being O, Rh positive, which was compatible in the laboratory. The surgery was an emergency procedure for massive hemorrhage. We obviously were most reluctant to operate and temporized more than we would ordinarily because of the bowel obstruction which left him in poor condition. Also, we felt that to operate upon him without a maximum amount of compatible blood available was to invite disaster. However, bleeding was uncontrolled and immediate surgery was indicated. He therefore was operated upon with only two units of Rh negative blood available. This was a number of years ago, and we did not have the stock of blood that we now have. There was no A negative blood available, nor was there any O negative; so he was given A positive blood reluctantly, but as a matter of dire necessity. The patient tolerated surgery well, but shortly thereafter he began to ooze from the original site.

Dr. Friedman, would you outline the pathogenesis of the bleeding here and its management?

Dr. Irving Friedman: Was there any evidence of reaction after the Rh positive blood was given?

Dr. Baker: None after the first unit; most of it was given during surgery, but no obvious signs of transfusion reaction were noted.

Dr. Friedman: The problem as exemplified by this case is probably one of the most frustrating of all the surgical and medical emergencies. The question is: (1) What happened? Why did it happen? What could we have done at the time it happened to help the patient? (2) What could we have done — and very simply — to evaluate the patient for a coagulation defect? What test could we do at the operating table or during the severe bleeding episode that could help us find the best possible therapy?

Here was a patient with perforation and intermittent bowel obstruction who had had a number of blood transfusions at several week intervals, so we have the feeling there is good reason for him to ooze by virtue of poor tissue and capillary integrity, as well as the lesion from which he is bleeding. Then a massive hemorrhagic episode ensues, and, despite all efforts to keep up with the blood loss, he goes into profound shock and does not recover.

My first consideration is: Did he have any bleeding difficulties before surgery? In the history apparently there was no such indication. He had no history of bleeding or family history of bleeding, and I am sure this was looked into. The fact that his first surgical procedure was performed without any bleeding tendency would speak for the fact that this was an acquired condition associated with, or a consequence of, the subsequent events in his clinical course. Therefore, one has to be guided by what happened, why it happened, and what to do to evaluate it.

Commencing from the time he started oozing, there are simple procedures to do, right at the table. For instance, the site of bleeding is important. In this case it was from the wound and G. I. tract. First, see if the blood clots as it comes out; however, more important, see if it *stays clotted*. In fibrinolysis, severe bleeding itself will induce a vicious circle of continued clot lysis. The cycle is so vicious that it not only embraces fibrinogen loss but also destruction of other elements, including platelets, prothrombin components, and plasma clotting factors. An incoagulable state may result with severe persistence of bleeding. The *first sign* of fibrinolysis may be the appearance of clots in the wound, but a few minutes later the clots are gone.

One should next get a blood film from the finger or the wound, have the slide stained with Wright's stain, and examined for platelets. The prompt diagnosis of thrombocytopenic purpura can be made if the platelets are grossly diminished. A platelet count, of course, is absolute evidence of thrombocytopenia. We know the

bleeding time is prolonged by observing the oozing wound. The Rumpel-Leeds test does not help much because the patient and his vessels are under great stress, and this test will be positive under these circumstances without platelet defect.

Always of importance is the complication of so-called "vascular fragility" — toxic fragility of the capillary that occurs during infection, during severe obstruction of the bowel with toxemia, or with acute azotemia.

In this case there were only two pints of Rh negative blood available; so Rh positive blood had to be given. I don't think there was any incompatibility but since he had had Rh positive blood previously, he could have real difficulty. What would happen? Some hemolysis would occur, and this would liberate red blood cell thromboplastin. What really happens in these severe hemolytic reactions is that there is intravascular coagulation, with laying down of small thrombi, thereby depleting platelets, prothrombin, and plasma clotting factors. Ultra-fresh whole blood is important, therefore, in treatment. If fresh blood is not available, fresh frozen plasma is a magic substitute. What we are giving with this material is the antihemophiliac and various plasma factors associated with thromboplastin formation. In a limited way, fresh frozen plasma contains platelet material. The only difficulty with fresh frozen plasma is that it lacks whole platelets, so the one function missing is clot retraction. However, some hemostasis may usually be achieved by supplying the other factors mentioned.

I would emphasize that if you do not have whole blood to give to these patients, then give fresh frozen plasma at 1, 2, or 4-hour intervals, according to demands of hemostasis.

Then we come down to the fact that we can treat the fibrinolysis by giving adequate fibrinogen. This is also done at time intervals in 1 to 2 gram doses until bleeding and fibrinolysis cease.

If bleeding persists despite these measures, one suspects factors other than that of coagulation, such as vascular fragility. Blood and plasma only help maintain vascular integrity by raising the blood pressure and improving tissue oxygenation.

When vascular fragility is a possibility, steroid therapy is indicated, and I prefer hydrocortisone, 100 mg. in each bottle of intravenous fluids.

Therefore, in emergency bleeding during surgery, clot observation, studying a blood film for platelets, and keen observation of the site and type of bleeding may yield valuable information as to clotting ability, fibrinogen adequacy, fibrinolysis, and platelet numbers.

How can we evaluate the patient without any bleeding tendency for elective surgery? The surgeon wishes that there were some way to screen these patients to make sure they do not bleed, instead of having difficulty arise in the operating room. There are two things I should say about this. First, the best test you have is the history. It is better than any laboratory technique we have available for screening. Don't lull yourself into the false security of doing a routine bleeding time, clotting time, or even a platelet count. If you do these three and they are normal, or even do a prothrombin time, which is normal, you might think the patient cannot bleed. But this is not the case, as bleeding still can occur. Pay attention to the history! If the patient says, "I once had a tooth pulled and I bled," or if he says, "I had surgery before and I had trouble; they had to give me blood," pay heed to what he tells you. Too often we don't pay attention to an obvious history. If the patient has a family history or personal history of bleeding, he deserves every possible evaluation before surgery, especially if it is an elective procedure. Is there any evidence of anemia, systemic disease, or infection that might predispose to bleeding? The platelet count is unnecessary if we do a good blood count. We report platelets as adequate, increased, or decreased on the blood film. If there are adequate or increased platelets in the film, there is no point to doing a platelet count, assuming a good technician is looking for the platelets.

If the platelets are adequate in number, it still does not mean they are functioning properly, and thrombasthenia may exist. A good bleeding time will help to rule this out, but this is not done with 1 of the 27 varieties of hypodermic needles stuck into the earlobe, yielding a drop of blood. Use a good sharp surgical scalpel so that a small vessel is severed. It should normally bleed for one or two minutes; bleeding longer than three or four minutes is abnormal.

If there is a known bleeding history, these simple procedures may not be enough. We may

want to do the prothrombin consumption procedure which tests the formation of thromboplastin in an indirect way. We test how much prothrombin is used after clotting in a one hour period. If there is poor consumption, we know something is wrong in thromboplastin formation, and we can go on and pinpoint the lesion by further tests. We have gone as far as taking the patient's own elements, i.e., platelets, serum and plasma, and testing them to see if the platelets and other factors are functioning. If they are not, we can tell you which factor is deficient. This is called the thromboplastin generation test.

Dr. Baker: If you are able to determine the specific factor that is deficient, how do you treat the defect?

Dr. Friedman: This depends on what the defect is. If it happens to be thrombocytopenic purpura, find out why he has it. Is it leukemia or idiopathic thrombocytopenic purpura? This is a most important and often drastic form of bleeding. For surgeons it takes on even greater importance since the question of splenectomy comes up; platelet infusions may be needed to correct the bleeding.

If, however, the platelets are adequate and this patient has a mild hemophilia, then fresh frozen plasma can be given at three or four-hour intervals before and after surgery. If the patient has a congenital hypoprothrombinemia or a labile factor deficiency, we can carry him through with the same procedure. We do not need to give fresh blood unless the patient is anemic. Also preferable, if available, is matched plasma to avoid reactions from multiple infusions.

If, after all these tests, you find there is no evidence for thrombopenia, hemophilia, or prothrombin deficiency, and if the bleeding time is prolonged, then we are in the realm of platelet function defect. This does happen and it is important because it causes quite a bit of bleeding at surgery. This defect may be detected by prothrombin consumption or thromboplastin generation tests. If these procedures are not available, and you find a prolonged bleeding time, I would advise you to have both fresh frozen plasma and ultrafresh whole blood at surgery. Certainly it is better to have these materials ready in advance than to try to obtain them when bleeding occurs.

This brings to mind certain difficult situations. Occasionally a patient without history or evidence of bleeding diathesis by the various tests will bleed under the stress of surgery. You have to test that patient during the surgical procedure. This is something that no one can predict. This brings to mind the old advice, "Even if the prothrombin time is normal, give vitamin K." We used to say that it was terrible to give vitamin K when the prothrombin time was normal. Previously, if it was found that the patients bled less with vitamin K, our answer would be that it was spontaneous cessation of bleeding. There is actually some good evidence that under the stress of surgery, especially in the patient with a history of hepatitis or gallbladder disease, or with borderline liver involvement, the prothrombin time may become prolonged. We have tested for this and found abnormalities, so perhaps empirically giving vitamin K or fresh blood in certain instances is not a bad idea. One should not do this routinely, however.

Therefore, we have to consider the patient not only before he goes to surgery but we also have to think about what happens when he is anesthetized. If we remember these facts, we can prevent bleeding or correct it once it occurs.

Dr. Baker: What is the situation in the patient who shows an irreparable bleeding diathesis after 18 to 24 infusions of compatible blood, who has a negative Coombs test, and in whom the other tests are normal?

Dr. Friedman: There is an enormous literature on what happens when you give 10 or more pints of blood. Some have wondered whether the blood is diluted so that the platelets are decreased or of poor quality. The literature is actually very confusing, but the current thought is that the patient is developing thrombocytopenia or platelet function defect because of dilution with blood poor in platelets; also, there is some depletion or dilution of the plasma factors. Another concept is that the patient develops antiplatelet antibodies or antithromboplastic substances, and some workers have claimed the finding of these inhibitors. The difficulty lies in trying to decide how much is dilution and how much is that vicious circle in the patient who requires this amount of blood, is in great stress and shock, and develops fibrinolysis during shock and bleeding.

Are we giving too much citrate or anticoagulant? Sometimes we are told to give large amounts of calcium. Actually, I think that has been overemphasized. Everybody gives calcium, but the patient usually continues to bleed and I do not think that calcium is the major factor in the bleeding. Much more important is the depletion of platelets or plasma factors. One way to get around this is to give ultrafresh blood every few hours. If you have to give 15 to 20 pints, it is obvious that you are not going to get enough fresh blood to replace this loss, but along with bank blood you can give fresh frozen plasma, which will give many of the factors that would be in the fresh blood. The only thing you miss is the value of the whole platelet in clot retraction.

Dr. Snyder: Does the pH of banked blood have anything to do with massive bleeding? If calcium is not important, is it necessary to give it? Is Premarin® or any of the related substances of benefit?

Dr. Friedman: I would give calcium, but you do not need very much. The clotting system is so set up that you need very small amounts for the clotting mechanism. You need not give more than 1 to 2 Gm. every six hours, as calcium is adequate for clotting in extremely small amounts. The role of pH of replacement blood has not been documented as being of importance. The use of Premarin is based on (1) its direct action on the vascular or fibrinoid tissue of the mucous membrane, and (2) its increasing the effect of factor V. I have read the reports on the use of Premarin carefully, and the changes are so slight that I cannot get excited about it. I think that if the bleeding stops with Premarin therapy, it is usually a coincidence.

Question: Is there any factor in the menstruating female which is related to bleeding?

Dr. Friedman: Early in menstruation there is a fall in platelets, and menstrual blood has both thromboplastic and fibrinolytic factors. This comes up in abruptio placenta, for instance, where there are fibrin emboli laid down or there is severe fibrinolysis. Whether the amniotic fluid is really proteolytic or whether the shock and bleeding which occur cause the fibrinolysis we cannot say. It is very difficult to know whether it is part of the cycle started by something else or whether it is responsible, but the treatment for fibrinolysis is still fibrinogen in large dosage.

Dr. Baker: If a patient has intravascular clotting, would you supply enough fibrinogen in fresh frozen plasma?

Dr. Friedman: No, additional fibrinogen probably would be required.

Dr. Roscoe C. Giles: What about the use of protamine sulfate?

Dr. Friedman: The best place for this substance is in heart pump surgery because that is an artificially induced type of heparinemia. In the ordinary postoperative or postpartum bleeding we have not been impressed by its use.

Question: What about the role of body warmth in these reactions?

Dr. Friedman: If fibrinolysis is pronounced enough, it will continue anyway. You may have heard an obstetrician say, who sees bleeding while he is doing an episiotomy, "I don't understand; I'm doing an episiotomy and the patient is bleeding and there is clotting, but I looked down at the pan five minutes later and the blood is all liquid." Fibrinolytic activity occurred at room temperature, but fibrinolysis is usually somewhat more rapid at body temperatures.

Case 2

Dr. Baker: The patient was a 50 year old Negro male, transferred to the Cook County Hospital from another institution five days after herniorrhaphy for an incarcerated umbilical hernia. It was learned that he bled from his wound postoperatively and was reexplored, but no single bleeding point was found. Despite 4 units of whole blood and 4 units of fresh frozen plasma, his oozing continued. He was also given Adrenosem®, steroids, Premarin and thromboplastin.

The history revealed only that he had bled considerably following a tooth extraction at the age of 10. This was learned only after persistent questioning, which further disclosed that the maternal grandfather died after tooth extraction and two male grandchildren bled abnormally.

Physical examination revealed a midline vertical umbilical herniorrhaphy incision with a 20 by 16 cm. wound hematoma causing marked elevation of the wound edges. There was discoloration around the wound and out to both thighs. The wound exuded clotted and fluid blood; no other hematomata or ecchymoses were seen.

His hematocrit was 22 per cent, hemoglobin 6.8 Gm., WBC 9,000 with 82 per cent neutro-

phils. The other laboratory findings were:

Platelets — 493,000
Bleeding time — 4 minutes
Clotting time — 16 minutes
Tourniquet test — negative
Complete clot retraction — normal
Prothrombin time — 13 seconds, 85%
Prothrombin consumption — normal

Despite infusion of 17 units of fresh frozen plasma over six days, the wound continued to ooze for 19 days intermittently, finally stopping only after all sutures were removed. Every time we lifted the dressings, liquid blood would ooze from under the clot. Finally, in desperation, we took all the sutures out, and it was only then that bleeding stopped.

Dr. Friedman, we have here a patient with a questionable history of bleeding who was operated upon, discovered subsequently to be a hemophiliac, but who continued to ooze despite adequate therapy and with these laboratory findings. We would like to hear your comments.

Dr. Friedman: This is a case with a history of some bleeding, and yet, if one were to do the usual coagulation tests, only one area would give a clue and that is the clotting time of 16 minutes. The way we do that test here, this is normal because we do not shake the tubes too fast or often and 5 to 16 minutes is considered normal. Also the bleeding time here is borderline. Clot retraction is normal, the prothrombin is normal, and the prothrombin consumption rate is well within normal limits. So we are faced with a patient bleeding postoperatively despite fresh frozen plasma; other drugs directed at vascular integrity were also given without effect. On subsequent thromboplastin generation test we found in this patient a mild antihemophilic factor deficiency.

Actually, this patient should not have too much bleeding. In similar cases we have done actual AHG (antihemophilic globulin) assays and found the normal is 30 per cent. If one has 15 per cent or over, most of the time there will not be unusual bleeding; between 5 and 15 per cent of AHG levels, we recognize there will be mild bleeding and under 5 per cent severe bleeding. Incidentally, when one member of a family has a mild hemophilia, all the other hemophilic members of that family will also have a mild form. Let us say this patient has a 10 to 15 per cent level. Why did he bleed so much during surgery? Please keep in mind when these people are subjected to the stress of surgery, all tests are meaningless because they will bleed as much as any severe hemophiliac.

One possible explanation for the patient's failure to respond to fresh frozen plasma is the presence of a circulating anticoagulant. If a thromboplastin generation test were done during surgery, we would take his platelets, serum, and plasma and incubate this and with calcium make thromboplastin. Then we take this formed thromboplastin and do a prothrombin time. If we have liberated normal amounts of thromboplastin, we should get a normal reading of 10 to 12 seconds prothrombin time, but here it was 20 seconds. Something was wrong with his generation of thromboplastin. If we substituted normal platelets, it would still be abnormal. If we substituted serum, it would be abnormal because he does not have the serum type of defect. We know that the antihemophiliac factor (AHG) is found only in fresh plasma; so when we substituted normal plasma into the test, normalization occurred, which means he has true hemophilia. The fact that normal plasma could correct the test rules out circulating anticoagulants, because these inhibit any AHG introduced into the test. Therefore, there were other defects present, probably vascular.

We would have to say then that this was a mild hemophiliac who got into trouble at surgery by virtue of a complicated AHG deficiency. Since the test was done during the episode and since spontaneous anticoagulants will last three to five months, once they form, it would be difficult not to find them. One point to remember about circulating anticoagulants is that they commonly appear when red cells are given. If we can keep away from giving red cells in correcting hemophilic patients, we are more likely to prevent the occurrence of circulating anticoagulants. It is best to give a known hemophiliac typed plasma from family or friends, and save that patient from the formation of circulating anticoagulants.

Also, the donor can then be tested for hepatitis, which we feel is a real threat. If there are circulating anticoagulants present, the patient presents a difficult problem. You have to massively infuse these patients with plasma to get an effect. I do not mean to say that if the patient

is very anemic one should withhold blood to relieve the severe anemia. It would be wonderful if we could set up a bank of typed plasma for each known hemophiliac. They could bring in their own family and friends and we would put the typed plasma away for their use.

Dr. Baker: With regard to fresh frozen plasma, how should you time the administration of it? This patient received 3 units in the morning and then none until the next day.

Dr. Friedman: The best timing for AHG is to administer it at four-hour intervals, keeping it up over 24 to 72 or 96 hours on a four-hour schedule. In that way you can get away with less plasma. One unit can be given every four hours, and more benefit will accrue than by giving 2 or 4 units in the morning and repeating it the next morning. One can also carry many of these patients through tooth extractions or surgery, when these are necessary.

Dr. Baker: The second patient received steroids; do they have any effect on the anticoagulant (anti-AHG)?

Dr. Friedman: In massive amounts, steroids may help to offset the anti-AHG effect. Unfortunately it has a rather slight effect. I would suggest hydrocortisone, 100 mg. intravenously every four to six hours. (300 to 400 mg. a day.)

The effect of steroids on bleeding is interesting. One can take a patient with 4+ Rumpel-Leeds test, give 2 tablets of cortisone, and he will become negative. The thing to remember is that steroids have two actions. First, there is some effect on the vascular integrity. In experimental adrenalectomized animals a direct effect can be demonstrated on the vascular integrity by the use of steroids. Second, they effect an increase in platelet numbers. In the antibody situations — e.g., circulating anticoagulants (or anti-AHG) — it is worthwhile trying steroids. In hemophilia with infection, when the infection is clearing, some benefit may result from giving steroids for a few days. I think that benefit occurs because of the vascular effect of these agents.

Question: Is there any rationale for giving ACTH and hydrocortisone in combination?

Dr. Friedman: I have done that. In severe purpura when the patient was receiving hydrocortisone and I was worried about producing a severe Cushing effect, I have added ACTH. The basis for use of ACTH is the specific effect it may have directly on the vascular structure.

Dr. Baker: I want to thank Dr. Friedman for this extremely enlightening and educational session. The concepts he has advanced should be most useful to all of us.

Summary and Conclusion

1. The classical theory of blood coagulation involved two steps, enzymatic in nature:

$$\text{Step 1: Prothrombin} \xrightarrow[\text{Tissues, Platelets}]{\text{Thromboplastin}} \text{Thrombin}$$

$$\text{Step 2: Fibrinogen} \xrightarrow[\text{Ca}]{\text{Thrombin}} \text{Fibrin}$$

   The formation of thromboplastin was later discovered to result from the interaction of platelet and plasma factors, as a sub-step essential for step 1. Platelets and antihemophilic globulin are indispensable for the formation of thromboplastin in plasma.
2. Subsequently, upwards of 30 factors have been described and fitted into the complicated mosaic of the coagulation mechanism. New factors are being added as more investigation is done in this field.
3. A *single* abnormality of one of the hemostatic mechanisms may not result in bleeding if all others are normal.
   Contrariwise, severe spontaneous bleeding usually requires the involvement of *more* than one elementary hemostatic mechanism.
4. Therapeutic agents may affect more than one hemostatic mechanism simultaneously. As an example, vitamin K_1 in the treatment of Dicoumarol®-induced hypocoagulability corrects both hypoprothrombinemia *and* a state of increased vascular fragility which exists. The nature of the vascular change leading to the increased fragility is unknown.
5. The commonest cause of postoperative bleeding is inadequate hemostasis. This should always be considered first, especially when bleeding is localized to one site or wound.
   The next common mechanism active in postoperative bleeding is the infusion of incompatible blood leading to a hemolytic trans-

fusion reaction. This leads to thrombocytopenia and decrease in prothromboplastins with subsequent oozing.

6. Other causes of postsurgical hemorrhage are:
   (1) Hypoxemia (increases capillary permeability)
   (2) Massive trauma (decreases fibrinogen, thromboplastin precursors)
   (3) Intravascular clotting
   (4) Acute or chronic hepatic insufficiency (decreased prothrombin)
   (5) Thrombocytopenia
   (6) Hemophilia
   (7) Idiopathic
7. The treatment of hemolytic transfusion reaction involves:
   (a) *Stop infusion,* collect venous blood sample and urine.
   (b) Massive doses of steroids IV
   (c) Mainteuance of blood pressure (vasopressors)
   (d) Alkalinization of urine which is of questionable value (must not over-infuse Na as M/6 lactate)
   (e) Push IV fluids (2-3 liters in 8 hours) when possible.
   (f) Rematch, administer compatible blood, if needed.

Some problems of medical care

The whole program for medical care of the American population is receiving comments from many directions. The public intends to obtain medical security in some form, and there is recognition of the fact that health services rank with housing, industry, employment, food supply, and social security as among the essential needs of the nation. Much of the progress in this field represents the extension of life expectancy at birth during this century from 47 to 70 years, which has been made possible by "engineering" out of the environment many of the conditions that have produced death especially among infants and children. The problems today are particularly those of the aged and infirm which cannot be met on a mass basis but only on an individual approach since each person represents a health problem that is not likely to be solved on a community-wide basis. This approach is not fully understood and there are many who believe that the phenomenal advances in life expectancy during the last fifty years can be repeated. This is highly unlikely.

Parallel with the "aging" is the "younging" of the population due to the greatly increased birth rate and the high survival in the early years of life. This "younging" is now drawing attention because by 1970 40 per cent of the population will be under 20 years of age. Also a point of interest is the nomadic character of our American people as witnessed by the fact that 33 million changed residence last year. This point has a bearing on any consideration of state regulated health programs since about 10 million of these individuals crossed state or county lines last year. These points must be considered in determining how medical services in the country are to be organized in the future since many people do not have the long time services of a family physician when they move to another area. It is obvious, therefore, that in many instances the physician must deal with only a segment of a person's life. The conditions often prevent a doctor from following patients and families on the basis of the longitudinal concept of illness which involves the whole life span of an individual or family and gives due consideration to the hereditary, environmental, educational, economic, psychological, and emotional aspects of health and illness and the further fact that in older age groups the problems are not so much those of diagnosis and treatment as they are of management, nutrition, and psychosocial factors. *Report of the President of the Josiah Macy, Jr. Foundation, Nov. 16, 1960.*

Emotional Trauma in Surgical Patients

James Scott, M.D., *Coal Valley*

Emotional trauma is a response to a stressful experience. In a surgical practice it is a daily occurrence, but its concept is at times poorly understood. The emotional stress of surgery is not a specific condition; however, it gains importance as a clinical entity because it becomes superimposed on an existing disease. It aggravates, conceals, or distorts symptoms; and it becomes a handicap in preoperative and postoperative management. There is general agreement that the discovery of an incurable disease, a colostomy, or mutilating procedures requires radical adjustment in personal plans and outlook in family and business life. The patient may not be able to cope with an emotional adjustment of such magnitude, and the assistance of a psychiatrist may be required. The majority of surgical conditions, however, require a short hospitalization and do not result in permanent disability. This presentation refers only to these lesser cases.

The causes of emotional trauma in surgical patients are numerous. Discovery of an illness, uncertainty about its outcome, pain and discomfort, anticipation of diagnostic and therapeutic procedures, and embarrassment of helplessness of gastrointestinal and urinary difficulties are contributing factors. The stress of inactivity and isolation and economic difficulties may be present.

Symptoms

An unpleasant experience provokes an emotional response in everyone. This stress is easily absorbed by the emotionally mature individual, and he presents no problem in management. The oversensitive and overreacting patient with latent or overt psychoneurotic tendencies, however, will develop a clinically significant response. The symptoms of emotional strain are known to all physicians, and the surgeon faces them as they appear in the preoperative, the operative, or in the postoperative periods.

Prior to the operation, the patient exhibits apprehension, restlessness, sleeplessness, anxiety, and depression or paranoid ideas. He may become uncooperative or refuse some procedures outright. During the operative period the anesthesia poses a major problem. The patient expresses fear of local and spinal anesthesia. The anxiety may reach the dimensions of panic and may require preoperative medication. At times, the anesthesia must be induced in the ward.

In the postoperative period, increased restlessness and nightmares are observed. The patient complains of discomfort out of proportion to the performed procedure. In his anxiety he refuses to turn or be turned, to breath deep, to cough, or to ambulate. Reactive depression and prolonged gastrointestinal and urinary disturbances may be present. The postoperative management is further complicated by poor tolerance to injections, catheters, and gastric tubes. Orders concerning diet, medication, and smoking are frequently ignored. Corman and his associates have found that the preoperative emotional pattern and the postoperative behavioral disorders cannot be coordinated satisfactorily.[1] Thus, the appearance, the magnitude, and duration of these symptoms is unpredictable.

An important implication of emotional trauma is the possible permanency of its symptoms. In the past there was a great deal of concern about permanent psychic scarring in the young child, especially in the sensitive 1-5 years old.[2,3] For this reason various aspects of emotional sequelae in the average surgical studied most intensively in children[4] but provide no satisfying answer.

Transient behavioral disorders were observed postoperatively for several weeks to several months. We failed to observe any permanent emotional sequelae in the average surgical patient. In our experience, all individuals with excessive reations to stress of an operation have had signs of psychoneurosis prior to the pro-

From Myers Clinic, Coal Valley, Ill.

cedure. These patients reacted to all stress of life with undue anxiety.

Management

The management of emotional trauma is part of the physician's daily work. An understanding and compassionate attitude, explanation of the course of the disease and of the operation are fundamental. Assurance backed by the authority and integrity of the physician offers a sense of security. In short, a good doctor-patient relationship solves most difficulties. For an oversensitive individual, the more taxing diagnostic procedures, and local and spinal anesthesia should be omitted. An increased amount of sedatives or tranquilizers may be required. Depressive reactions call for appropriate management.

Children require more attention than adults, although the basic management is similar.

Summary

Emotional trauma is a normal response to disease, hospitalization, and surgery. The emotionally mature and stable individual easily absorbs this stress.

Oversensitive patients develop clinical symptoms of emotional trauma. Although these psychoneurotic and behavioral disorders are transient, they may interfere with the preoperative and postoperative management.

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Sleeping sickness in Africa

In general, the territory in which eradication of sleeping sickness has been most nearly achieved is that in which some of the most severe and explosive epidemics took place but where tsetse fly control was understood and was courageously and effectively applied. Where there have been no attempts at entomological control, because it was considered impossible or too difficult and costly (in the forest zone), or where it was possible but not used (around Bamako), incidence of the disease has often been remarkably reduced; but there has always remained a low, apparently irreducible minimum at which it was held only by vigilant application of mass treatment and mass prophylaxis, with the slightest interruption resulting in a recrudescence. *Morris, K.R.S.: New Frontiers to Health in Africa, Science Sept. 9 1960.*

Suicide by digitalis

This case was of interest, first, because of the use of digitalis as an agent for suicide. Although there have been a few isolated reports of its use in attempted suicide, the selection of digitalis is a most unusual agent for this sort of effort. It was unfortunate that the exact dose of digtalis taken could not be determined. Secondly, the electrocardiographic records are of interest. . . . the variability of rhythm over a short span of time was striking. Thirdly, this offered an attempt to review the various agents of benefit in severe digtalis poisoning, and finally, the hemorrhagic manifestations in the mycardium are of special interest. *Dewey W. Johnston, M.D., and Richard V. Price, M.D. Case Report of Suicide with the Use of Digitoxin. Texas J. Med. June 1960.*

Pregnancy in the Presence of Extrahepatic Portal Hypertension — *A Case Report*

Gilbert D. Fish, Jr., M.D., and Warren Mills, M.D., *Freeport*

An intensive search of the literature has failed to reveal a report of pregnancy occuring in the presence of extrahepatic portal hypertension. We have recently witnessed such a combination, the salient feature of which are described below.

Case report

M.M., a white, single female, age 17, first sought attention for spontaneous hematemesis in April, 1953. Bleeding ceased under conservative management. When a second episode occured four months later, she was transferred to another institution for further evaluation and treatment. A diagnosis of "splenic anemia" was made and an elective splenectomy performed, splenomegaly having been observed during both episodes of bleeding. Two months following surgery she experienced her third bout of hematemesis, which was once again controlled by conservative means. An esophagram failed to show any evidence of varices. Her fourth and fifth experience with hematemesis followed soon thereafter. She received her first transesophageal vein ligation at this time. Ten months later she had a recurrence which again responded to nonsurgical treatment. A liver biopsy was reported normal. In June, 1955, she was referred to still another institution where a portacaval shunt was attempted; but because the portal vein could not be found, the wound was closed without any definitive procedure. The diagnosis at this third institution was that of portal hypertention due to portal vein thrombosis secondary to pyelephlebitis.

In January, 1957, the seventh bout of severe bleeding was unsuccessfully treated by conservative means, thus necessitating an emergency "portacaval" shunt utilizing a branch of the superior mesenteric vein for anastamosis to the inferior vena cava. The portal pressure at the time of surgery was 40 cm. of water. In about seven months she again bled and was controlled conservatively, only to return again two months later with still another episode of severe hematemesis. An elective second transesophageal vein ligation was performed in November.

Shortly before this last procedure the patient married and was strongly advised against pregnancy because of the possibility that changes in the intraabdominal pressures occurring with pregnancy might cause recurrence of esophageal bleeding. However, she became pregnant in February, 1959. She was followed closely both by ourselves and the obstetrical service. Her pregnancy was uneventful except for a mild three-day episode of tarry stools during her second trimester that responded well to conservative management. She underwent an elective Caesarian section and was delivered of a normal female child. There has been no further bleeding to this date, a period of 18 months since her last transesophageal vein ligation.

The only pertinent points in this patient's past history were 1. Empyema occurring at age six, details of which are unavailable. 2. Elective appendectomy performed at age eleven.

Otherwise no serious illnesses were known to exist, and her family history was completely negative.

Discussion

A number of questions are obviously raised by this case, but unfortunately, few answers are available. What is the etiology of the portal hypertension? It seems fairly safe to say that the block present in this patient is extrahepatic. This is evidenced by the absence of liver pathology as determined by normal liver profile

From the Freeport Clinic, Freeport, Ill.

studies, a normal liver biopsy, and also by the fact that no portal vein could be found by an experienced surgeon. This same surgeon initially suggested the diagnosis of portal hypertension secondary to old pyelephlebitis.

This would appear to be a reasonable hypothesis, but what was the cause of the pyelephlebitis? The appendectomy performed in 1951 was uneventful, since no mention was made in the protocol suggesting a pyelephlebitic complication. Another possibility comes to mind with reference to an associated pyelephlebitis secondary to empyma with septicemia present in the patient at approximately age six. The last consideration, of course, is that of some congenital defect such as cavernous transformation of the portal vein.

It is unfortunate that the patient's splenectomy prevented the later use of the splenic vein for splenorenal shunt, particularly in view of the fact that no portal vein was found at a subsequent operation.

This patient's pregnancy was discussed in great detail with reference to the possible effect of pregnancy on portal pressure. We were unable to find any information concerning the effects of pregnancy or the three stages of labor on portal pressure. Hoffbauer, Bollman, and Grindlay[1] studied a number of factors influencing portal pressure in dogs. They found that any act which raised the intraabdominal pressure, such as defecation or vomiting, caused a rise in the portal pressure. The Valsalva maneuver caused a definite rise in the portal pressure. Adno[2] in writing on cirrhosis and pregnancy concluded that it was reasonable to expect a gradual rise in portal pressure system as the abdominal cavity was filled by the growth of the pregnancy. However, he also felt that the patient should be allowed to go through spontaneous labor and that Caesarian section should be performed by using the same criteria as for other obstetrical indications.

It seemed to us, however, that with the evidence on hand concerning the fairly marked rise in portal pressure from the Valsalva maneuver, augmented by the associated severe straining that accompanies the first two stages of labor, that this would undoubtedly contribute greatly to the possibility of recurrent hematemesis. Therefore, we felt it was a lesser of two evils to electively terminate this patient's pregnancy via a Caesarian section.

Summary

1. Pregnancy occurring in the presence of extrahepatic portal hypertension is described.
2. The multiple procedures necessary to control her hematemesis prior to pregnancy are enumerated.
3. The possible etiology of the portal hypertension in this case is discussed.

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The new vs. the old

James Reston, writing last year in the New York Times on the subject of national goals, neatly summarized the issue in a sentence as meaningful for medicine as for government. "It is the ancient conflict, beyond partisan politics, between the pessimists and the optimists, between those who want to concentrate on stopping bad things and those who want to concentrate on positive new programs, between those who still have the zest and audacity to pioneer and those who are weary and find it more comfortable to defend the familiar. *Lindsay E. Beaton, M.D. A Platform for Medicine in Arizona. Arizona Med. Aug., 1960.*

Suppurative Cholangitis —

Report of a Case Treated with Corticosteroids

E. Richard Ensrud, M.D., Norris L. Brookens, M.D., and Jack C. Cooley, M.D., *Urbana*

Intrahepatic obstructive jaundice due to obstruction of the finer biliary radicles may be classified as follows:[1] (1) Acute or chronic suppurative cholangitis secondary to ascending infection along the biliary tract, (2) Cholangitis caused by drugs such as chlorpromazine, (3) Primary cholangitis which may occur without exposure to known toxic agents and is probably an uncommon manifestation of infectious hepatitis, and (4) Growing neoplasms, xanthomatosis, and various infectious processes which impinge upon the smaller bile ducts.

Suppurative cholangitis[2] is an inflammation of the bile ducts and smaller biliary radicles usually resulting from biliary stasis. The most common causes of bile duct obstruction are a common-duct stone and neoplasms of the gallbladder, bile ducts, or head of the pancreas. However, biliary obstruction may occasionally be secondary to a chronic pancreatitis with involvement of the common bile duct. Suppurative cholangitis in the absence of biliary obstruction is extremely unusual.

The symptoms and signs of suppurative cholangitis are

1. Jaundice with or without colicky pains.
2. Chills and irregular but marked fever.
3. A tender and usually enlarged liver.
4. Occasional splenomegaly.
5. A neutrophilic leucocytosis.
6. Bilirubin in the urine.
7. Positive blood culture.

Complications are generalized toxemia, metastatic abscesses, hemorrhage secondary to prothrombin deficiency, and hepatic coma.

Case history

A 40 year old, white male with jaundice was admitted to the Carle Memorial Hospital on March 19, 1958. In August, 1957, he had his first episode of right upper quadrant pain; it was severe for several hours and persisted to a lesser degree for three days. From then until March, 1958, he had two other similar episodes.

On March 7 he developed fever, chills, and right upper quadrant pain, which lasted three days. Concurrently he noted the jaundice present at the time of hospital admission. For about two weeks before he had pruritis and acholic stools. The physical examination, aside from the obvious jaundice, was negative.

The chest x-ray was normal. X-ray examination of the esophagus, stomach, and duodenum were negative; colon and terminal ileum were negative by barium enema and proctoscopy to 16 cm. revealed no abnormality. The hemoglobin was 12.2 Gm. 100 cc. and the erythrocyte count was 4,400,000/cu. mm. The leucocyte count was 11,500/ cu. mm. with a neutrophilia of 70 per cent. The erythrocyte sedimentation rate was 67 mm. (Westergren Method). The fasting blood sugar was 103 mg./ 100 cc. The alkaline phosphatase was 8.5 Bodansky Units/100 cc. The cephalin-cholesterol flocculation test was negative, and the thymol turbidity was 2.6 units. Prothrombin time was 40 per cent of normal, but after four days of vitamin K therapy, it was 100 per cent. The urinalysis was negative except for the presence of bile in the urine.

Since cholelithiasis and choledocholithiasis were suspected, the patient underwent exploratory laparotomy on March 20. The stomach, small intestine, and colon were normal. The liver appeared grossly normal except for a jaundiced hue. The gallbladder was of normal size with no palpable stones. The common bile duct was thickened, inflamed, and dilated to about two and one-half times normal size. The thickening of the common bile duct extended from the hilus of the liver into a large firm palpable mass in the head of the pancreas. The

From Carle Hospital Clinic, Urbana.

Presented at the Section on Medicine, Illinois State Medical Society Meeting, May 26, 1960.

bile duct was opened, and white bile was aspirated. No calculi were detected in the common bile duct, and a T-tube was inserted.

Several biopsies of the pancreas and one from the common bile duct showed chronic inflammation and fibrosis.

Postoperative course

The patient made a good general postoperative recovery. However, despite the T-tube drainage of 900-1000 cc. of greenish bile, which started two days postoperatively, the jaundice persisted. On March 24, the total bilirubin was 14.1 mg./100 cc., and the direct bilirubin was 6.7 mg./100 cc. The patient was discharged from the hospital on March 30.

A cholangiogram on April 26 showed a narrowed area in the common duct 3.5 cm. from the duodenum, but no obstruction was visualized, and the dye entered the duodenum. On April 26 the total serum bilirubin was 17.0 mg./100 cc., and the direct reacting bilirubin was 7.8 mg./100 cc. A second cholangiogram taken on July 12, 1958 was negative; however, on July 13 the patient had chills and fever up to 103 F. Tetracycline therapy was instituted so that by July 18 the fever and chills had subsided, and the patient was feeling better.

For six months postoperatively, the patient remained deeply jaundiced, although the T-tube continued to drain bile. He felt fairly well but was anorexic and lost 15 pounds in weight. His medical treatment consisted of (1) a high protein, high carbohydrate, low fat diet; (2) Ketochol®, (3) Menadione® 10 mg. t.i.d., and (4) a multiple vitamin capsule. The bilirubin remained elevated with the highest peak occuring on July 19, when the total serum bilirubin was 21.8 mg./100 cc., and the direct bilirubin was 11.4 mg./100 cc.

On September 17 a third cholangiogram revealed that the T-tube was obstructed proximally, and it was, therefore, removed. On the same date the total bilirubin was 19.6 mg./100 cc.

On September 24 steroid therapy consisting of methyl prednisolone 12 mg. per day in divided doses was instituted. The patient was next seen on October 1 and showed marked subjective improvement. Clinically the jaundice appeared to be greatly diminished. The methyl prednisolone was reduced to 6 mg. per day, and on October 15 he was feeling well and his appetite had returned. On this date the direct-reacting bilirubin was 1.5 mg./100 cc. and the total bilirubin 4.0 mg./100 cc. The prothrombin time was 100 per cent.

His clinical improvement continued. On November 5, total serum bilirubin was 1.4 mg./100 cc., hemoglobin 15.2 Gm./100 cc., the erythrocyte sedimentation rate 14 mm., and a urinalysis was negative. On Jan. 12, 1959, the total serum bilirubin was normal—1.0 mgs./100 cc.—and the prothrombin time was 80 per cent. On this date the methyl prednisolone was decreased to 4 mg. per day. A bromsulfalein dye retention test performed on February 12 was in normal range, 7.5 per cent of the dye being retained at the end of 45 minutes.

For the major portion of 1959 the medications used were methyl prednisolone 2 mg. per day, Ketochol, and a multiple vitamin preparation. The patient returned to work and remained in good health until October, when he began having abdominal cramps and 8 to 12 loose, explosive stools per day that were occasionally bloody. A pancreatic extract was prescribed without benefit. Diarrhea and abdominal cramps persisted, and the patient was hospitalized for further investigation. The general physical examination was negative. The hemoglobin was 13.2 Gm./100 cc. and the erythrocyte count 4,600,000/cu.mm. The leucocyte count was 14,200/cu.mm. with a neutrophilia of 70 per cent and an eosinophilia of 10 per cent. The sedimentation rate was 34 mm. The fasting blood sugar was 88 mg./100 cc. and the blood urea was 26 mg./100 cc. Serum amylase was 41 units/100 cc. and in normal range. The total bilirubin was 0.6 mg./100 cc. The microscopic examination of a stool specimen was negative for ova and parasites. Proctoscopy to 15 cm. revealed the typical mucosal changes of chronic ulcerative colitis, and x-rays showed that the descending colon and distal transverse colon were involved. Pancreatic calcifications were not seen on x-rays of the abdomen.

The patient has had a good response to the medical treatment of his chronic ulcerative colitis. At the present time the medical regime consists of (1) a bland diet, (2) methylprednisolone 16 mg./day, (3) Azulfidine® 4.0 Gm./day, and (4) Metamucil®.

To this date there has been no detectable recurrence of his jaundice, and the patient has not developed a pancreatic insufficiency secondary to

the chronic involvement of the pancreas. From the history it is probable that the patient has been having episodes of ulcerative colitis for approximately 15 years. However, barium enemas and proctoscopies in 1948 and 1958 were reported negative. The first positive colon x-ray and proctoscopy were obtained in November, 1959.

Comment

The conventional treatment of a suppurative cholangitis consists of supportive measures such as intravenous fluids and vitamin K, use of appropriate antibiotics, and when possible, surgical relief of the condition resulting in the obstruction of the biliary tree.

Steroid therapy in recent years has been reported effective in cholangiolitic hepatitis, which may be considered a variant of infectious jaundice. Overholt and Hardin[3] reported four cases of cholangiolitic hepatitis occurring among 722 cases of infectious hepatitis. Steroid therapy employed in these four cases resulted in a prompt return of appetite and well being, and after four days total serum bilirubin was decreased considerably. Summerskill and Jones[4] also recorded four patients with cholangiolitis hepatitis who were benefited by corticosteroid therapy. Albot[5], on the other hand, considered corticotrophin and steroids of little value in the usual variety of cholangiolitic hepatitis.

In our patient, who had a suppurative cholangitis secondary to pancreatitis and common bile duct obstruction, the conventional measures of T-tube drainage, diet, vitamins, and vitamin K failed to produce a remission. His jaundice persisted for approximately six months, and because of the reports of beneficial effects of corticosteroids in cholangiolitic hepatitis, a trial of methylprednisolone was deemed advisable. Within a few days after the institution of methylprednisolone, the patient's subjective improvement was marked, and within three weeks his bilirubin had decreased 79.6 per cent. In approximately eight weeks' time the serum bilirubin had returned to normal level. The prothrombin time remained normal without continued administration of vitamin K, previously necessary. A bromosulfalein dye retention test performed approximately five months after the initiation of methylprednisolone was within normal range.

Summary

A case of cholangitis secondary to pancreatitis with common bile duct obstruction is presented in which a marked clinical remission occurred after the initiation of steroid therapy. Prior to the institution of steroid treatment, six months of conventional therapy consisting of T-tube drainage, diet, antibiotics, multiple vitamins (including vitamin K), and bile salts had failed to improve the patient's condition.

It was also noted that one and one-half years after the onset of the cholangitis, the patient developed a chronic ulcerative colitis. It is believed that the cholangitis and chronic ulcerative colitis have no etiological relationship, but that their occurrence in this patient was a coincidence. Steroids are often used in the treatment of chronic ulcerative colitis, but in this patient the chronic ulcerative colitis began while the patient was receiving a small maintenance dose of methylprednisolone.

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People are much more alike inside than they are on the surface. —*Verne Burnett*

Pyloric Obstruction From a Cyst Containing Brunner's Glands

Frank J. Saletta, M.D., F.A.C.S., Casimir W. Tuleja, M.D., and George J. Rukstinat, M.D., *Chicago*

The duodenum, although the shortest portion of the small bowel, has the highest incidence of congenital stenosis and atresia per unit length.[1] The reasons for narrowing of the bowel are found in embryological studies which have shown that during the second month of fetal life, the intestine is a solid cord in one phase of its development. Subsequently vacuolization and canalization usually re-establish a normal lumen. There is a high potential for abnormalities in the duodenum with its embryological connections to the stomach, pancreas, and liver, and because of its complex course with fixed and mobile portions. Fortunately the duodenum and its contiguous structures usually develop normally, even the submucosal glands of Brunner. Occasionally, however, these glands may form polyps, as in the 11 day old infant reported by Golden,[2] or adenomas, as shown by Hudson and Ingram.[3] More recently McQuitty and Levy[4] have reported five benign duodenal polyps, three arising in Brunner's glands and two from the mucosal glands. Further involvement of Brunner's glands is recorded by Hoffman and Grayzel,[5] who found that 10.6 per cent of all benign tumors of the duodenum arose from them.

With improved reading of x-rays, a better understanding of duodenal lesions is apparent. Surgeons can develop techniques to deal with the problems. It is with the hope that further interest in these pathological conditions will bring fruitful results that the following case is presented.

Case Report

A healthy boy weighing 3.9 Kg. (8 lbs., 10 oz.) was delivered by Dr. C.W.T. at Holy Cross Hospital on Dec. 8, 1959. Six weeks after birth the child weighed 10 lbs. and seemed to be in satisfactory condition. On Feb. 2, 1960, however, the child was taking less nourishment and occasionally vomited after feeding. Relaxing drugs and sedation failed to give relief, and three days later a mass was palpable in the pyloric region.

X-ray studies revealed a delayed emptying time of the stomach, and there was marked narrowing of the distal portion of the pylorus. At no time during the study was the duodenum demonstrated. At the end of three hours a very small amount of barium reached the small bowel, but the rest remained in the stomach. The roentgenologic diagnosis was congenital hypertrophic pyloric stenosis.

Surgery was performed by Dr's. C.W.T. and F.J.S., on Feb. 10, 1960, through a paramedian muscle-splitting incision in the right upper quadrant. The duodenum contained a pear-shaped glistening tumor on its anterior aspect 4.5 cm. in diameter (Fig. 1). A horizontal incision into the tumor released a clear mucoid liquid from a well defined sac. A nasogastric tube was easily introduced into the duodenal lumen after pressure from the tumor was relieved. The lining of the sac was completely

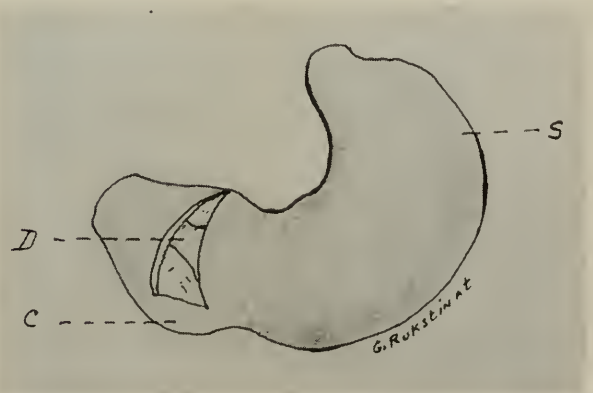


Figure 1. Schematic representation of conditions found at operation illustrating: S—the dilated stomach and C—cyst compressing the duodenum at D.

From the departments of surgery and pathology of Holy Cross Hospital, Chicago.

The View Box

Franz Gampl, M.D., *Chicago*

This 38 year old Negro female entered the hospital with the complaints of chills, cough, and exertional dyspnea of a few days' duration.

She had had repeated bouts of respiratory infections during the last two years. These were accompanied by chills and afternoon temperature rises up to 102 F. She thought she had lost some weight. The patient was asymptomatic in the interval between these episodes.

The physical examination revealed a patient who was chronically ill, moderately emaciated, and in moderate respiratory distress. The blood pressure was 120/80; the pulse, 80 per minute and regular; respiration, 20 per minute, and the temperature, 98.6 F.

The anterior posterior diameter of the chest was increased, and the lungs were hyperresonant to percussion.

On auscultation fine rales were heard in both respiratory phases, especially at the lung bases, and expiratory wheezes were present throughout both lung fields.

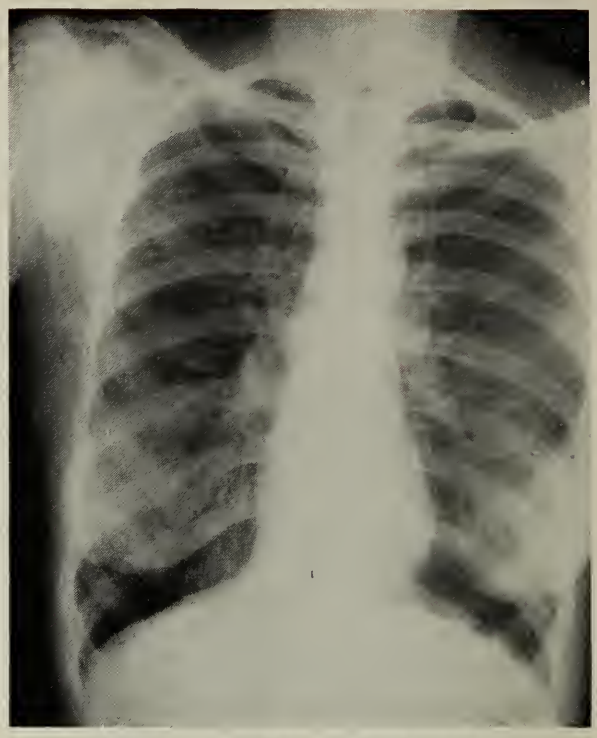


Figure 1. Admission roentgenogram.

The heart was normal to percussion and auscultation.

There was no clubbing of the fingers.

What is your diagnosis?

1. Empyhsema
2. Brochiectasis
3. Bronchitis
4. Pulmonary cystic disease (vanishing lung)

(*continued on page 29*)

Pyloric Obstruction

(*Continued from page 25*)

dissected from the thinned duodenal wall. Finally the redundant tissue of the sac was excised and the upper and lower edges were approximated with interrupted fine chromic sutures. Recovery was excellent and the child was sent home after nine days.

The pathologic report (Dr. G.J.R.) indicated that the specimens consisted of two tubular masses, one 38 mm. long and 1 in diameter and the second 22 mm. long and 1 to 8 in diameter. The lumen of each was patent, and the structures resembled thin hypertrophied membranes 0.5 mm. thick. The outside of the mass was rough because of recent detachment. The histologic structure of the membrane was musculofibrous with numerous hemorrhages. The lining was glandular, and the glands were imbedded in fibrous elements and lacked a tunica propria.

The glands were typical of the Brunner variety and were filled in varying degrees with secretion. The pathologic diagnosis was benign cyst of the duodenum with contained Brunner's glands.

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MEDICINE IN THE OUT-OF-DOORS

ICE

Julius M. Kowalski, M.D., *Princeton*

ALL THE MISHAPS of summertime recreational pursuits upon lakes and rivers are compounded when these bodies become ice covered. The desperation of rescue crews trying to recover a person from beneath the ice is immediately apparent to any witness to such a tragedy. Forethought, basic knowledge of ice conditions, and common sense exercised by skaters, ice fisherman, and other winter enthusiasts would reduce this needless hardship.

As cold weather advances, bays and quiet areas of lakes freeze over first and their centers generally are covered last. These events are controlled by wind action and water density. In order to freeze over, all the water of a lake must reach 39 degrees, its greatest density, and as its temperature drops to 32 degrees, the colder water becomes lighter and stratifies at the surface. Were it not for this phenomena, ponds and lakes would freeze from the bottom upward becoming solid ice sheets from top to bottom, and much of our aquatic life as we know it would be nonexistent.

Clear ice results when the freezing is slow on a calm night; suspended particles have had time to settle. The surface is usually glassy smooth. Opaque (gray) ice forms when minute air bubbles are at the surface from wind action or when snow is falling at the time of freezing. The clear ice becomes opaque from subsequent snows. The weight-carrying capacity of either type of ice, for all practical purposes, is the same.

Thermal energy exchanges between the ice and ambient air, wind pressure, rise and fall of water levels, solar radiation during the day and radiation cooling at night—these factors are responsible for leads (cracks) developing in the ice and the accompanying cannon-like booming. For some, these audible changes in ice sheets hold a peculiar fascination. This does not indicate unsafe ice, for it occurs in the Arctic pack which is ten or more feet thick.

Ice thickens as sub-freezing weather continues, provided the sheet is not covered by snow. Trapped air spaces in snow make it a good insulator; and if its depth is a foot or more, very little thickness is added to the ice below. A week of sub-zero weather need not necessarily mean that ice is safe if it has been blanketed to an appreciable depth.

With increasing sunlight hours of late winter, the crystalline structure of ice changes. (The "twinning" of this hexagonal crystalline system gives rise to the picturesque leafy designs on frosted window panes.) Before break-up, long perpendicular shafts appear in the ice like bundles of pencils, and it becomes honeycombed or "rotten." It is treacherous. Where one had trod with assurance for weeks, a man's body now can drop suddenly through the ice without as much as a crack for a warning.

Safety on ice

To assure safety on ice as found here in the Midwest, be mindful of the following: Never venture on recent ice alone. The time-honored Boy Scout "buddy system" is a must. Each should carry an 8 to 10 foot pole or length of rope. Breaking through in shallow water is no more than a hair-raising, uncomfortable experience, but over deep water and alone it can turn into disaster.

Test the ice. Chop a hole in it and measure. A minimum thickness of four inches is necessary to support a man. If only this minimum requirement is met, don't concentrate the weight of several persons in a small area, but spread out. Because a number of people are on the ice on the far side of a lake, don't assume that ice beneath you is equally solid. The ice on that side might have been thickening for a week or longer because of a wind protecting bluff, peninsula, or bay.

Give wide berth to projecting rocks, stumps, logs, and piling. Ice tends to be thinner near

obstructions because of its constant expansion and contraction about them, and also because of their heat absorbing qualities on sunny days.

Avoid rivers and channels. Except for the northern tier of states, the weather is seldom cold enough for a prolonged time to make this ice safe. Currents are continually eroding the under-surface of the ice, water levels fluctuate frequently, and warmer water arising from springs enters streams and rivers which makes for ice of uneven thickness. For the same reason, stream inlets and outlets at lake junctions are hazardous.

A heavy snowfall shortly after freeze-up can be a trap. Test for the minimum four inch thickness frequently. Be wary of ice far from shore until all the land be locked in winter's fastness. Wind and wave action and turn-over of water density in deep water may have delayed safe ice thickening there by a week or more.

Some stomp where angels fear to tread. That's why cars are driven onto frozen lakes. A minimum thickness of two feet is necessary to support a car, and even then one can hit a thin spot. Trucks and "cat trains" transport heavy, bulky supplies over frozen lakes to lodges for the coming summer in the northern states and Canada, but there the ice is three feet or more.

The breakthrough

But should the most dreaded of ice experiences befall one, what then? Remember that the air locked in typical bulky winter clothing will buoy up a person in water for several minutes at the least. The victim breaking through the ice will not plummet to the bottom like a rock. Kicking the legs, as in any of the conventional swimming styles, will bring him to the surface and the arms should be stretched over the ice ledge. More vigorous kicking while pulling with spread out arms, as one does in the breast stroke, will ease one onto unbroken ice. Do not attempt to stand up yet! This only concentrates the weight on thin ice and another break-through may follow. Continue to ease yourself in spread-eagle fashion over the ice and in the direction you have just traversed for at least ten feet before attempting to stand. Here is where the long pole becomes a life saver. When it is placed across the break-through hole, the trunk of the body should be worked up over the pole, and it should be kept under the body as one makes his way to firm ice, thus distributing the weight. If a second person is present, he should lie flat upon the ice, hold on to one end of the pole, and after the victim has a firm grasp on the other end, slowly pull him upon the ice. The length of rope is used in like manner. Don't stand up until firm ice is reached.

This information and the several suggestions will be helpful to all winter sports-minded individuals and contribute to their welfare.

May you keep your feet warm and your matches dry.

Most business problems require common sense rather than legal reference. They require good judgment and honesty of purpose rather than reference to the courts.—*Edward N. Hurley*

Think of your own faults the first part of the night when you are awake, and of the faults of others the latter part of the night when you are asleep.—*Chinese Proverb*

The View Box

—diagnosis and discussion (*continued from page 26*)

The heart was normal in size and configuration. The lung fields were hyper-radiolucent and showed bilateral basilar and perihilar cystic areas having the appearance of saccular bronchiectases, best seen on the cut-out taken from the right lower lung field (Fig. 2).



Figure 2. Cut-out from right lower lung field.

These cystic areas when seen on the plain chest roentgenogram are highly suggestive of bronchiectasis. The bronchogram made after admission revealed the pathognomonic "bunch of grapes" appearance of saccular bronchiectasis (Fig. 3).

Pulmonary function studies revealed a decreased maximum breathing capacity of 43 per cent and considerably prolonged time vital capacity. These findings were interpreted as compatible with severe obstructive ventilatory insufficiency, and suggestive of emphysema, obstruction of the large bronchi, or both.

Pancreatic enzymes from the duodenum showed normal values.

The etiology of bronchiectasis:

A. Congenital: Mucoviscoidosis (abnormal sweat electrolytes and abnormal pancreatic enzymes). Kartagener's syndrome with dextrocardia and sinusitis.

B. Acquired: Postpneumonia (acute or chronic). Obstruction due to foreign bodies, tumors, or hilar nodes.

Clinical findings: Bronchorrhea, hemoptysis, recurrent bouts of respiratory infection, and systemic symptoms such as retardation of growth, weakness, loss of appetite, shortness of breath, mild anemia, and metastatic abscesses.

Therapy: Surgical resection when localized to one lung segment or lobe.

When generalized, the patient was managed conservatively with postural drainage, bronchial dilatators, and antibiotics.

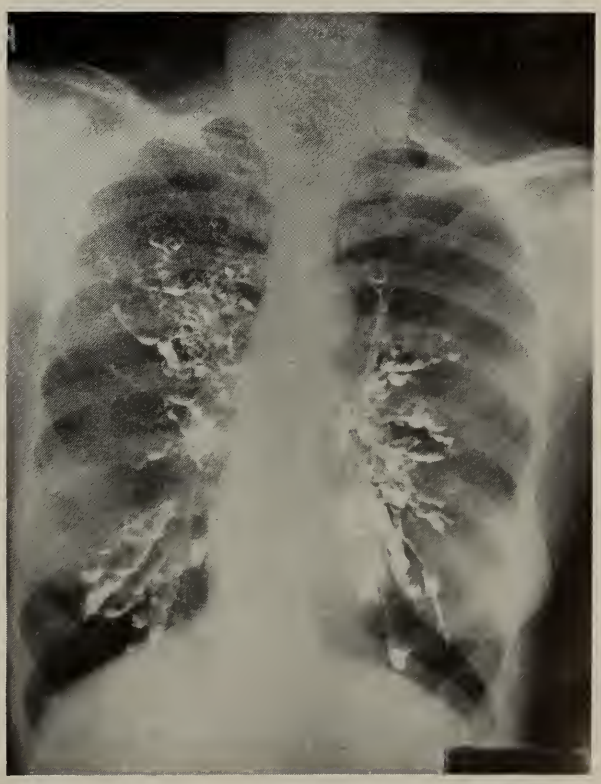


Figure 3. Bronchogram.

Clinical Evaluation of a

Diiodohydroxyquin Suspension For Seborrheic Dermatitis

W. N. Slinger, M.D., *Chicago*

The halogenated quinoline derivatives have been used extensively in dermatologic therapy. All members of this group of drugs used locally seem to have some antibacterial, antifungal, antieczematous, and antiseborrheic qualities.

In recent years, dichlorohydroxyquinaldine (Sterosan®) and chloriodohydroxyquinoline (Vioform®) have been used more commonly for topical therapy than other derivatives, primarily in local treatment of eczematous and pyogenic conditions. They usually are prepared as ointments, creams, or lotions and frequently are compounded with various other ingredients, such as hydrocortisone, tars, urea, antibiotics, and salicylic acid.

In preliminary screening trials with the quinoline derivatives for their antiseborrheic effects — particularly in paired comparison evaluations with various selenium compounds — diiodohydroxyquin U.S.P. appeared to be the most desirable. Three to five per cent diiodohydroxyquin creams and ointments have been used effectively for seborrheic dermatitis for many years, although only a few papers have referred to this specific use.[1,2] Toxic effects resulting from percutaneous absorption have not been reported. The index of sensitization seems quite low.

Because fairly good results can be expected with the use of diiodohydroxyquin locally for glabrous seborrheic dermatitis, it seemed reasonable to try the drug suspended in a detergent for use as a shampoo.

Associate, department of dermatology, Northwestern University Medical School.

Materials for this study were supplied by Abbott Laboratories.

Materials and procedures

A 10 per cent suspension of diiodohydroxyquin in a shampoo having approximately the following composition:

Diiodohydroxyquin	10%
Bentonite	4%
Nacconal O.A.	17%
Glyceryl Monoricinoleate	1%
Perfume	0.5%
Water q.s. ad	100%

The procedures of the clinical studies carried out some years ago to determine the efficacy of selenium disulfide used in a shampoo were used as the guide for the present project.[3]

For the purpose of a more meaningful clinical study the patients were classified into the three groups on the basis of the criteria indicated:

(1) *Moderately Severe* — Primary involvement of the scalp in which the amount of scaling, erythema, seborrhea, and subjective sensations could be reduced but not controlled completely with a shampoo of ordinary detergents employed twice weekly.

(2) *Severe* — Involvement of the entire scalp, marked objective and subjective symptoms. The condition is unchanged by any amount of shampooing with common detergents.

(3) *Scalp and Glabrous Skin Involvement* — Patients who exhibit varying amounts of seborrheic dermatitis of the scalp with concomitant seborrheic lesions elsewhere on the body.

Directions for shampooing were given as follows:

1. Wet head thoroughly with warm water.

2. Apply 1 to 2 teaspoons of shampoo and work into scalp until lather is obtained.
3. Rinse, and repeat process.
4. Allow shampoo to remain in contact with scalp for a minimum of five minutes.
5. Rinse scalp thoroughly.
6. Repeat shampoo every five to seven days.

Control Procedure — A separate group of control subjects was not used. The multiplicity of factors influencing the course of disease in any one subject, the capriciousness of the disease, and the improbability of exactly matching patients with similar cutaneous disease makes a control group of little value. (Results based on such a group easily could be misleading.) Instead, each patient was evaluated carefully with close attention given to past history in respect to duration, involvement, variations in the course, and response to all treatments.

Observations

The diiodohydroxyquin preparation was employed as a shampoo by nearly 350 patients with seborrheic dermatitis of the scalp of varying severity. Of these patients, 151 were observed closely for periods ranging from three months to two years thus permitting some preliminary conclusions regarding therapeutic value.

An attempt was made to see each patient at two-week intervals, but, unfortunately, this was possible in only one third (50) of the cases. However, no patient was included among the charted subjects who was not observed at least on two occasions after beginning the use of the experimental shampoo.

During the test period, clinical observations were made of each subject and interpreted in the following terms, according to more or less arbitrary criteria:

(1) *Complete control*: Absence of subjective complaints and disappearance of all desquamation and erythema.

(2) *Moderate improvement*: No subjective complaints, such as itching and burning, but some existing evidence of the disease.

(3) *Mild improvement.*

(4) *No charge.*

(5) *Definite Extension of the disease.*

(6) *Irritation*: Evidence by eczematization of the involved areas without definite extension of the primary disease process.

Results

Generally, the patients with the mildest eruptions were the most responsive to treatment, although prompt improvement in severe eruptions was observed often.

Of the 151 patients observed for a minimum of three months, 46.3 per cent were completely controlled, 45.7 per cent were improved, and 8 per cent remained unchanged or slightly improved. All patients in the moderately severe group were completely controlled or improved. (Table 1.)

The least improved were patients in group 3, persons with both scalp and glabrous involvement. Only 26 per cent of these patients were completely controlled, but an additional 62 per cent were significantly improved.

The observation of some of the patients for longer periods of time — one to two years — gave impression of the rate of recurrence after the experimental shampoo was discontinued. The patients with severe involvement usually experienced a slow recurrence of the seborrheic dermatitis two to eight weeks after the discontinuance of the diiodohydroxyquin preparation.

Of all the patients included in the study there were 33 who had been using Selsun® previously

TABLE 1. Summary of Results Obtained in the Therapy of Seborrheic Dermatitis by the Use of the Experimental Shampoo.

Group	Classification	No. of Patients	Complete Control		Moderately Improved		Slightly Improved		Extention Irritation		No Change	
			No.	%	No.	%	No.	%	No.	%	No.	%
I	Moderately Severe	31	21	68	10	32	0	0	0	0	0	0
II	Severe	78	38	49	33	42	4	5	0	0	3	4
III	Scalp & Glabrous Skin	42	11	26	26	62	3	7	0	0	2	5
	Total	151	70	46.3	69	45.7	7	4.7	0	0	5	3.3

TABLE 2. SUMMARY OF THE OPINIONS OF THE PATIENTS WHO USED BOTH SELSUN AND THE EXPERIMENTAL SHAMPOO.

No. of Patients	Superior To Selsun	Inferior To Selsun	Equal Value	No Value
33	15	4	13	1

(Table 2). Fifteen of them stated that the diiodohydroxyquin shampoo was superior to Selsun, 13 found the shampoos of equal value, and one patient reported neither preparation of any value. Four patients preferred Selsun.

Six of this group felt that the experimental shampoo resulted in less oiliness than Selsun. Four patients reported that both Selsun and the diiodohydroxyquin shampoo made their hair excessively oily. Two patients with graying hair complained of the staining quality of both of the shampoos.

Comments

Clinical experience with the diiodohydroxyquin shampoo indicates that its antiseborrheic qualities are on par with selenium shampoos.

Experience also indicates that it is superior to the selenium-containing shampoos in several ways, all of great importance to the patient. First, the diiodohydroxyquin shampoo appears to be non-toxic; second, it is less staining, and, third, its use results in less oiliness. In addition, diiodohydroxyquin is a U.S.P. drug and is generally available to the physician as a powder. Therefore, it should be substantially less costly to the patient than the selenium-containing preparations. The physician can compound the drug in any concentration and in any vehicle desired.

Summary

A shampoo containing 10 per cent diiodohydroxyquin was used as a therapeutic agent for seborrheic dermatitis of the scalp. A group of 151 patients was observed for periods ranging from three months to two years. In 92 per cent of this group, use of the experimental shampoo resulted in significant improvement or complete control of the disease. Use of the shampoo did not effect a cure, however, for in most instances the seborrheic dermatitis returned when patients discontinued the treatment.

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Medical practice in New Zealand

The physicians in New Zealand are happy with the system which permits free choice of physician. The government pays a basic fee for each patient and permits the physician to charge an additional fee for the patients who can afford such fee. The practitioners throughout New Zealand do not participate in the care of patients referred to the government hospital. The patients are cared for by the hospital staff and are then returned with a report to the practicing physician. The physician does visit his patient in the hospital, but he carries no responsibility in that patient's management.

In addition to the four large government hospitals in the major cities, there are smaller hospitals operated by the government throughout New Zealand. Physicians in these areas are paid by the government to direct and participate in the care of patients in these smaller hospitals. No teaching is done in the smaller hospitals. A program of continuing graduate medical education is carried out for all physicians in the four major government hospitals. *Medicine and Medical Affairs in Other Countries. Medicine in Australasia. George C. Griffith, F.A.C.P. Bull. Am. Coll. Physicians, November-December, 1960.*



Should Physicians Be Covered Under Social Security?

WALTER L. OBLINGER, *General Counsel*

Physicians of Illinois have indicated renewed interest in the question of whether they should be covered under social security. This interest has been aroused by a recently conducted poll of Illinois physicians by an organization calling itself the Honest Ballot Association. According to statistics released by this organization, of 12,000 Illinois physicians polled by postcard, 4,967 answered; 3,964 voted *yes* and 1,962 voted *no* to the question, "Should physicians be included in the Federal social security program?" This poll was not authorized by the Illinois State Medical Society. It was conducted at the instance of the Physicians Forum, an organization which has among its purposes the compulsory inclusion of physicians under social security. Experience with polls indicates that the form of the question is highly important. For example, it is doubtful that results would have been the same had the question been phrased, "Should physicians be included under the Federal social security program on a *compulsory basis?*"

When the question of whether lawyers and dentists should be covered under the social security system arose several years ago, both of these professions were polled. I personally recall three of the questions asked of lawyers: (1) "Do you favor coverage under social security on a compulsory basis?" (2) "Do you favor coverage under social security on a voluntary basis?" (3) "Are you opposed to social security coverage?" Some materials explanatory in nature were enclosed with the questions.

I have no criticism of the questions or the way the poll was conducted. I remember discussing the matter with other members of the bar at the time and that it was the consensus that, while we were opposed to social security coverage on a compulsory basis, we did not want to exclude other lawyers from social security coverage on a voluntary basis if they wanted it. So the majority of the lawyers in Illinois voted in favor of voluntary coverage. The vote against compulsory coverage was overwhelming. However, when the matter was presented to the House Ways and Means Committee, the vote was interpreted as a vote in favor of the principle of social security, and the committee thereupon decided on the basis of this poll that the lawyers wanted it and hence voted them in on a compulsory basis. The same thing, I am told, happened to the dentists.

I doubt that lawyers would have voted for voluntary coverage if they knew or thought Congress would interpret their action as it did. You can understand my basic distrust of polls.

Coverage for older physicians

No poll should be taken unless the person polled has had an opportunity to listen to arguments pro and con. Most physicians who have attended such forums as the House of Delegates and reference committees of the American Medical Association are soon convinced that they want no part of social security. I believe that printed information accompanying such polls do not answer all of the questions in the physician's mind and generally tend to confuse rather than inform. Then, too, I question whether physicians generally have the time to read and inform themselves fully on such questions.

Insofar as social security coverage of any professional man is concerned, there are several things to bear in mind. It is true that those men approaching retirement age will, on the average, receive more from social security than they will put into it—*if they retire.* However, studies made by the American Medical Association and others substantiate the fact that since professional men become more valuable as they grow older and gain experience, they remain active much longer. The considerations which prompted social security do not obtain for most professional people. How many physicians and lawyers do you know who are in need at age 65? For physicians the Illinois State Medical Society has a benevolence fund, into which members pay $2 per year. In cases of need, financial assistance will be given physicians or their families.

For the younger man

For men just entering the working force, actuarial studies[1] disclose some rather sobering facts. Mr. Peterson's study, based upon the social security amendments of 1956, discloses that a new entrant coming under social security and his employer are paying $1.69 for every dollar the employee can reasonably expect to receive from the system. The self-employed person can expect to pay $1.25 for every dollar of benefits. Furthermore, benefits were increased in 1958 and again in 1960; therefore, those persons eligible for present benefits got more benefits for which they made no contribution. The cost of these benefits was passed on to the younger generation in the form of a graduated tax. This means that social security will become less of a bargain for new entrants of the future. Certainly this is no bargain for the younger physician.

There is another factor also. As the A.M.A. News of June 13, 1960, points out, the average physician retires at age 69 after working 40 years. Self-employed persons paying 4½ per cent of the first $4,800 earned (present rate) or $216 would pay $35,332.31 into the fund if interest is compounded at 6 per cent. Upon retirement, under his own private annuity program, the physician could expect to receive an income of $2,110.94 a year or $176.66 a month without touching the principal. The social security system pays only $116 a month maximum. In addition, the individual, under his own program, would control the fund; he could vary payments, change investments, or decide in a hardship year not to make any contribution at all, *and the principal would be his* and would come back to him or to his estate.

We have had inquiries from younger physicians who complain that they cannot get under social security and accordingly their families are being denied protection. We tell these physicians that they can purchase private insurance much cheaper than the government can provide it to them through this system. If they need broad coverage, they should consult with their insurance agents and find out what kind of coverage can be bought for $216 a year. And by 1969 they can buy more, for the social security rate is slated to increase for self-employed persons from 4½ per cent to 6¾ per cent of taxable wages ($4,800) or $323 by 1969.

Social security is not insurance. It has been sold to the country as a system whereby the government will collect premiums from the worker during his productive years to be held in a trust fund to be paid back to him upon retirement at age 65. Nothing could be further from the truth. There is no trust fund in the actuarial sense. Furthermore, 92.5 cents out of every dollar collected by the social security system is paid out in the form of present benefits to those persons now over age 65, or to those who have qualified for benefits in some other way. Only 7.5 cents out of every dollar goes into the so-called trust fund, and these funds are used primarily for the purpose of meeting variations in revenue from dips in employment. From the actuarial point of view, approximately $300 billion is needed in the trust fund to provide income to take care of approximately 40 per cent of the benefits as they accrue. At the present time, the contingent liability of the social security system exceeds the national debt of some $380 billion, and the accumulated trust fund under social security amounts to but $22 billion. No wonder the Physicians Forum and others want to get the physicians included under social security. They need the favorable experience they would get from the profession.

In discussing this matter with me the other day, a congressman admitted that members of Congress are fully aware of this problem. I confidently predict that the social security system will rumble to a halt within the next ten years or so, at which time the system will have to be

completely overhauled, new realistic tax rates adopted, and some portion of the revenue of social security provided out of general revenues. Physicians should not participate in such an unsound "insurance" program.

But the worst is yet to come. The socialists who borrowed this system from socialistic programs on the European continent were so intent upon getting the system started and sold to the American public that they used a variation of the old "come-on." They kept the rates at an unrealistic low figure, provided for full retirement benefits for persons who had not paid for them, and passed on the cost to coming generations through a system of gradually increasing rates. This system of mortgaging the future of our children and grand-children is morally reprehensible, and for this reason alone physicians should have no part of it. In 1959[2] social security contributions of $9,612 million amounted to about 43 per cent of estimated personal savings of $22,000 million. If the 1969 contribution rate of 9 per cent were in effect in 1959, social security taxes estimated at $17,300 million would be 78 per cent of personal savings of $22,000 million.

What Congress has done is to effectively reach down into the pockets of the working man of this country, and for a doubtful welfare-state purpose, has effectively decided for him how his money shall be spent. This process of deciding for the individual, what is good for him, and the taking away of his right to spend or control his earnings, will continue and get worse. As social security is a political plaything, we can expect every two years that some further liberalization of the program will take place for which the taxes will be raised in years to come. When the government takes away the individual's right to make decisions for himself, whether these decisions be right or wrong, it takes away his freedom. What a price to pay for security! We should rephrase the question from "Should physicians be covered under social security?" to "Should physicians sell out the heritage of our children for a mere $116 a month!"

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2. Ibid.

Flu or food infection

Most physicians are aware that much of the illness popularly referred to as summer flu, stomach flu or intestinal flu is, in fact, food infection or food intoxication caused by faulty food handling practices either at home or in a public establishment. Families have learned to accept an occasional gastrointestinal upset as something that is "going around" and that will pass in a day or two. For this reason, relatively few of such cases are treated by physicians or come to the attention of health officials. It is usually only when a large number of people are afflicted at once, as a result of eating a meal together, that any publicity is given to the episode. This is the reason that church or community dinners are so often incriminated while, as a matter of fact, many more cases occur independently from eating at a public restaurant. *F. L. Woodward. Food and Restaurant Sanitation Control. Minnesota Med. June 1960.*

Influences on the Rate of Growth of Expenditures For Voluntary Health Insurance

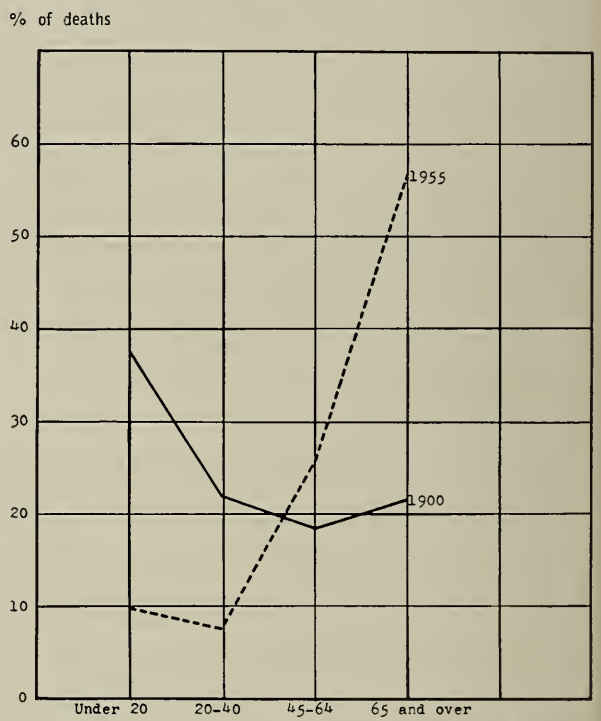
Walter Polner, Ph.D., *Madison, Wis.*

Marked improvements in the health of the people of the United States can be noted by any measure used. There is now lower infant mortality, lower maternal mortality, and longer life expectancy than in 1900 (Figure 1). Great advances have been made in the last two decades in uncovering the mystery of many diseases. These rapid and momentous contributions to the body of medical knowledge, and publication of the results of research, reflect the efforts that have been made to make modern medical benefits more readily accessible to a larger proportion of the population.

The more people seek to benefit from improved medical care standards, the greater the extent to which they will utilize the services of physician and hospital. The more these services are utilized, the greater the expenditure to whomever pays for medical care. Recent advances in the knowledge of medicine have contributed greatly to the expenditures for medical care. In turn, this increased expenditure has led to an enormous growth in the use of voluntary health insurance to pay for medical care since the end of World War II. In 1940, less than 10 per cent of the population of the United States had insurance to pay for hospitals bills. By 1958, 71 per cent, or over 123 million persons, had this type of coverage.

Much of this growth in voluntary health insurance has been due to group enrollment of persons at their place of employment. Because employers contribute toward the payment of this insurance, this growth also has meant a rise in the cost of labor to the firm. It is estimated that in 1954, employers contributed $652 million and in 1955, about $840 million, to pay for medical, surgical, and hospital benefits of their employees.

Figure 1. A comparison of percentage distribution of deaths by age in the United States 1900-1955



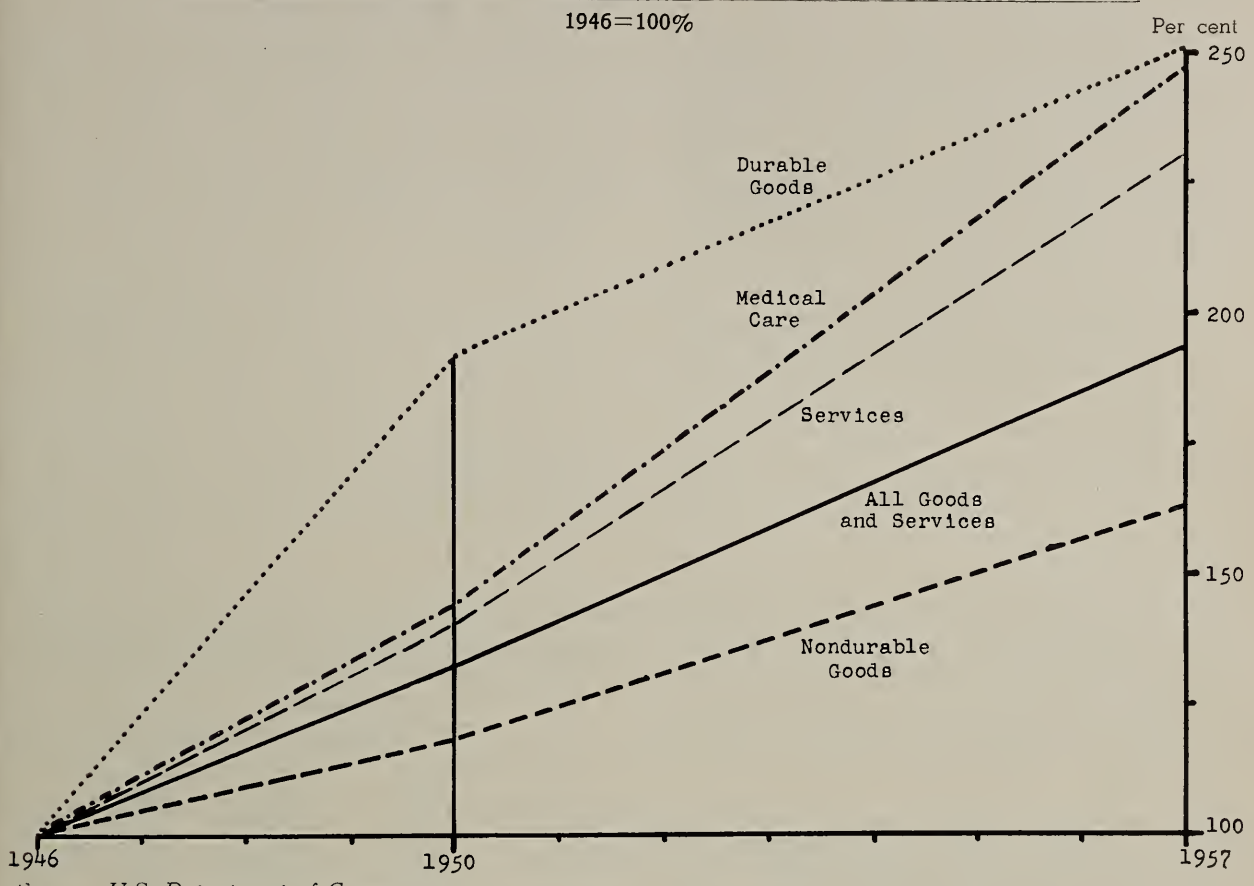
Source: Adapted from data in Statistical Bulletin, Vol. 39, Aug. 58, Metropolitan Life Insurance Co.

Today it has been estimated that employer expenditures have reached over $1 billion.

Many firms are concerned with the limits to over-all expenditures for these fringe benefits because of the rate of increase of these expenditures. Economics has long been known as "the dismal science" because it set itself the task, in the 19th century, of explaining to well meaning people that the world was too poor a place to permit them to accomplish all of their objectives without the development of certain complicating situations. The probability that industrial firms will experience a decline in expenditures for medical and hospital services for their employees in

Formerly research associate, economic research department, American Medical Association.

Figure 2. Personal consumption expenditures in 1950 and 1957 as a percentage of expenditures in 1946 for all goods and services, durable goods, nondurable goods, services, and medical care



Source: *U.S. Department of Commerce*

Figure 2a. Personal consumption expenditures for all goods and services, durable goods, nondurable goods, services, and medical care, 1950 and 1957, and 1957 expenditures as a percentage of 1950 expenditures

		Expenditures in millions 1950	1957	1957 Expenditures as % of 1950
All Goods and Services	(1)	$195,013	$284,442	145.9%
Durable Goods	(2)	30,351	39,926	131.5
Nondurable Goods	(3)	99,801	137,971	138.2
Services	(4)	64,861	106,545	164.3
Medical Care	(5)	8,741	15,051	172.2

(1) All goods and services is made up of twelve major categories: food and tobacco; clothing, accessories, and jewelry; personal care; housing; household operation; medical care and death expenses; personal business; transportation; recreation; private education and research; religious and welfare activities; and foreign travel and remittances—net.

(2) Durable goods include such things as furniture, kitchen and other houseware appliances, orthopedic appliances, and new cars.

(3) Nondurable goods include such things as purchased meals and beverages, tobacco, toilet articles, and drug preparations and sundries.

(4) Services include such things as barbershops, space rental value of owner-occupied nonfarm dwellings, maid service, burial expenses, legal services, and interest on personal debt.

(5) Medical care includes drugs and sundries, physicians' services, dentists' services, hospital services, and other medical care items, and excludes (here) funeral expenses.

Source: *Office of Business Economics, U. S. Department of Commerce, Survey of Current Business 38:7 (July) 1958, and unpublished data.*

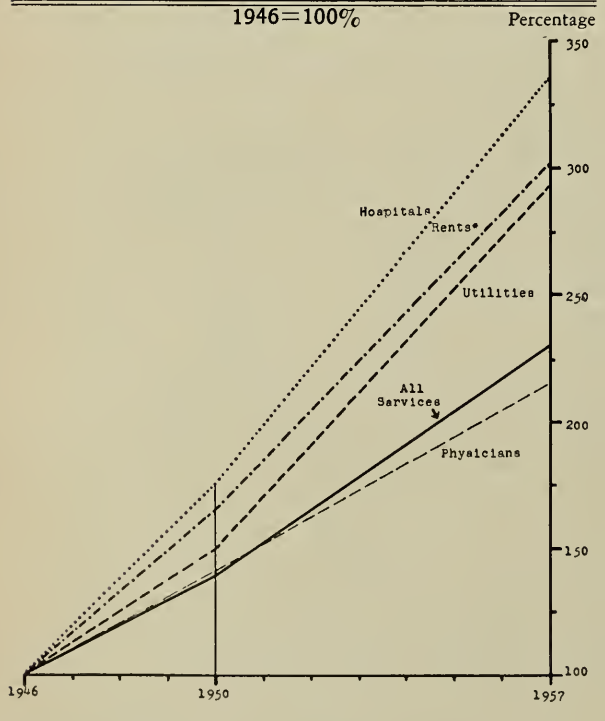
the near future is dim. All that can be hoped for is a lessening of the rate of increase in expenditures for these fringe items.

While medical advances have meant better health for all the people, the public—including many employers—is not primarily interested in the total costs of providing medical and hospital care, or even the cost to the average patient served, but rather with the direct out-of-pocket expenditures. Most people do not use the hospital in any one year and more and more of the hospital bill is being paid by the persons who are well or by firms in which most of whose employees never enter a hospital. The American Hospital Association estimated that over 23 million Americans used hospitals in 1958. Part of their bills in the hospital was paid by the other 100 million hospital insurance subscribers who did not go into the hospital.

Since industrial firms pay into the prepayment systems of voluntary health insurance, there is an immediate interest in the background of the rise in these firm expenditures. The first and most important influence is economic. We have had an inflationary economy since the 1940's. Prices for most goods and services have risen. Expenditures for all services, including medical and hospital services, more than doubled between 1946 and 1957 (Figure 2). If the service expenditures are viewed by themselves (Figure 3), it can be seen that hospital expenditures more than tripled during the time when most firms started to pay part of the costs of hospitalization for their employees and their families.

A recent study of medical care prices by the American Medical Association reiterates the well known fact that the indexes of medical care prices have risen in the 1950's faster than the consumer price index when 1947-49 is used as the base period (Figure 4). In an inflationary period this is to be expected; service prices lag behind commodity prices, but eventually they may catch up with other prices. As a Department of Labor study shows ". . . at the end of 1956,

Figure 3. Personal consumption expenditures in 1950 and 1957 for all services and selected services as a percentage of 1946 expenditures



*Space rental value of owner-occupied nonfarm dwellings. *Source: U.S. Department of Commerce*

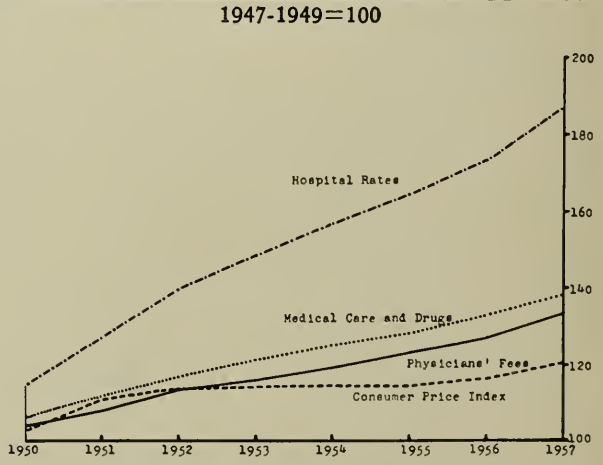
Figure 3a. Personal consumption expenditures for all services and for selected services, 1950 and 1957, and 1957 expenditures as per cent of 1950 expenditures

	(in millions)		1957 Expenditures
	1950	1957	as % of 1950
All Services	$64,861	$106,545	164.3%
Hospitals	2,037	3,884	190.7
Physicians	2,427	3,693	152.2
Rents*	12,117	22,064	182.1
Utilities	3,689	7,212	195.5

*Space rental value of owner-occupied nonfarm dwellings.

Source: Office of Business Economics, U.S. Department of Commerce, Survey of Current Business 38:7 (July) 1958, and unpublished data.

Figure 4. Consumer price index and medical care indexes



Source: U.S. Bureau of Labor Statistics

the prices of services, including medical care had almost regained the relationship they held with the prices of commodities in the mid thirties. Since the Consumer Price Index measures price changes relative to 1947-49, the base period, the fact that medical care prices had advanced relatively slowly during the previous decade is likely to be ignored." Most firms began to pay for these fringe benefits when service prices started to regain the relationship they held with the prices of commodities in the 1930's.

Sir Oliver Lodge has formulated a law to which I would like to call attention. Lodge's Law states, "The last thing in the world that a deep sea fish could discover would be salt water." To put it in today's language, to be aware of what has always been and what is still around us is difficult. When all attention is placed on the rise of expenditures for medical care, there may be a tendency to overlook the economic background of some of these increased expenditures of industrial firms. The increased expenditure for and use of all services, including medical care services, is another indication that we also are in a period of prosperity, a time when income that formerly would have been spent for necessities is being spent for services.

Since 1945, the nonagricultural labor force has grown from 44 million to 57 million. More money is being spent on fringe items because of the mounting numbers in the labor force and their families, and the installation of new fringe benefits since that time. In addition, the more income families have, the more likely they are to avail themselves of medical services. This is true of the middle income workers in manufacturing, earning an average of $4,513 per year in November 1958.

Since the greater use of medical and hospital services is a sign of a generally prosperous economy, expenditures for medical care cannot be isolated from the main thread of the economy. They should be viewed in relation to population changes of the labor force and productivity of the employees. Similarly, the rise of medical expenditures should be viewed by the employee in relation to his wages and his means of paying for medical care. Some data are available for comparison over a period of time.

Dr. Allan Gregg of the Rockefeller Foundation compared the per cent of the patient's wage needed to pay for hospital services in 1888 and 1948. I have attempted to bring the table up to date (Figure 5). In 1888 the average hospital patient in Hartford, Connecticut, paid approximately 21 per cent of his annual wage for an average hospital stay. Although the daily cost of hospital care has risen 30 times since then, by 1957 the average hospital stay cost the average industrial worker approximately 7.2 per cent of his annual wage. In 1888 there was nothing comparable to employer-paid voluntary health insurance or cash-illness allowances for the employee. It can be assumed that in relation to the

Figure 5. Schedule determining the per cent of income lost by the average hospital patient in 1888 and 1948, and by hospitalized industrial worker in 1957, in Hartford, Conn.

	Patient A 1888	Patient B 1948	Patient C 1957
Patient Day Cost	$1.09	$18.08	$32.77
Length of Stay	52 days	8.5 days	7.5 days
Cost of Hospitalization	$56.68	$153.68	$245.78
Yearly Income	$852.00	$2,500.00	$4,430.00
Work Day Income	$2.77	$8.14	$17.04
Days of Work Needed to Pay Hospital Bill	20 days	19 days	14 days
Work Days Lost While in Hospital	44 days	7 days	5.5 days
Total Days Lost	64 days	26 days	20 days
Per Cent of Income Lost	21%	8.5%	7.7%

Sources: Patients A and B from Challenges to Contemporary Medicine, Dr. Allan Gregg, Columbia University Press, New York, 1956; Hospital data for Patient C from American Hospital Association, Hospitals, J.A.H.A., Part Two, 32:15 (August) 1958, and Income Data from U.S. Department of Labor, Bureau of Labor Statistics, Monthly Labor Review 81:12 (December) 1958.

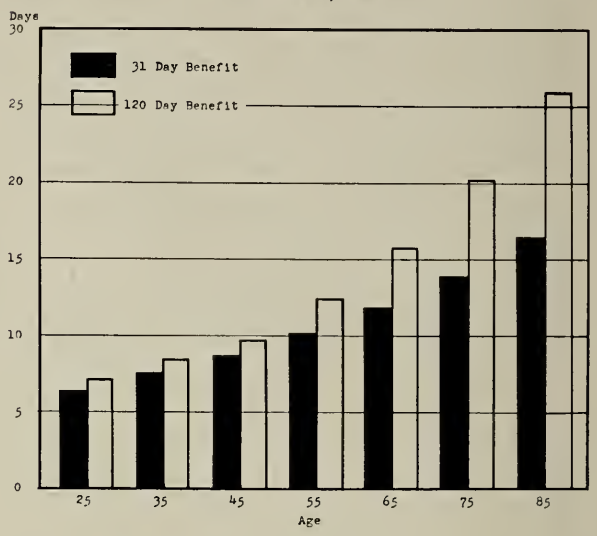
employee's wages, the average industrial worker today pays somewhat less than 7.2 per cent of his annual wage for an average hospital stay.

While the employee may be receiving these services, the employer is paying most of the bill. Employers pay wages to employees for their productivity. If wages are higher than the productivity of the individual employee, either the employee will be laid off or the firm's earnings are reduced. Employers cannot long afford to pay the costs of health insurance for employees unless they are making a profit from their operations.

The employer will pay for labor either in direct wages or indirect wage payments such as fringe benefits. But the employer will generally pay a wage bill for what is received in productivity. The cost of this insurance is part of this wage bill. If it were not paid for in indirect wage benefits, how much more would it be necessary to pay in direct wages? A large portion of the $1 billion now being spent for these insurance benefits would otherwise have to be given in the form of money wages. If the money spent for indirect wages had been available for use as incentive pay, it might have given firms more flexibility in meeting the problems of the recent recession. Since wage payments are made for the productivity of labor, would there have been any large money saving to industry had these payments for health insurance never been made?

Economic consideration must be given to the broadening and expansion of benefits. As benefits have expanded since the installation of the insurance plans, the over-all and per capita costs have risen. About the year 1950, many Blue Cross plans offered benefits covering from 14 to 21 days in the hospital. Today most Blue Cross plans offer coverage for at least 70 days. It is not too costly for a prepayment program to extend benefits from 30 to 70 days, but it may be fairly expensive to extend a plan from 14 to 21 days hospital coverage to 30 days of coverage. This type of broadening of benefits occurred since 1950. In addition to the costs of providing more benefits, there is more use of hospitals under the better plans (Figure 6), according to a recent report of the Insurance Department of the State of New York. As plans are improved, utilization and expenditures continue to mount.

Figure 6. Average number of days of covered confinement per year under hospital plans providing 31 day and 120 day benefits, males aged 25-85, New York State, 1957



Source: *Voluntary Health Insurance and the Senior Citizen, A Report on the Problem of Continuation of Medical Care Benefits for the Aged, State of New York Insurance Department, 1958.*

The nature of these benefits leads to two significant cost ramifications. Some firms attempted to broaden their benefits by providing payments for office and home care by physicians. It was thought thereby that the individual would be more free to see his physician for needed medical care and this would tend to lower admissions to hospitals where some diagnostic procedures are indicated. The recent studies of the Windsor Ontario Medical Plan and Saskatchewan Hospital Service Plan, which provide comprehensive physician care, throw doubt on this last assertion. Patients who saw the physician under these plans went to the hospital to a greater extent than those not covered by payment for physician services outside the hospital. From the point of view of the firms that adopted programs which paid the physician outside the hospital in an attempt to cut expenditures, the added contact with the physician and diagnosis of the patient's illness may have increased utilization of hospitals and immediate expenditures.

(*To be concluded*)

Dues Are Commensurate with the Need

Robert L. Richards, *Executive Administrator*

At the May, 1960, meeting of the House of Delegates a reference committee appointed to consider the subject of the Society's annual dues reported that *"the dues should be levied commensurate with the need."*

This view was adopted by the delegates in raising the annual dues $30, effective Jan. 1, 1961. Certainly the needs of organized medicine have never been greater, nor has the necessity for an effective organization to safeguard the interests of the public and the medical profession ever been more pronounced than today.

Here is the breakdown on how the dues will be allocated:

$58	— General fund
2	— Benevolence
20	— A.M.E.F.
$80	

Better service will result

The recent administrative reorganization of the Society, plus the more realistic dues, will permit a dramatic increase of services to the public and to the medical profession. With an adequate professional staff the Society, through its committees, can now embark upon expanded programs that will reflect with credit upon the medical profession. The purpose of this article is to explore briefy some of the new services and programs now in effect or planned.

Public Relations

At its meeting last May, the House of Delegates amended the Society's By-Laws to separate the Committee on Public Relations from the Committee on Medical Services, which deals with legislation. The stated function of the new committee is to "prepare and submit a public rela-

The following article is the second in a series being published from time to time in the Journal and describing progress (being made) in the reorganization of the Society. In this article the Executive Administrator reports on some of the new or increased services to individual members and component societies made possible by the increase in dues. Every member should take an interest in the activities of the new administrative staff. We recommend these reports to your special attention.
H. Close Hesseltine, *President*
E. A. Piszczek, *Chairman of the Council*

tions program for the Illinois State Medical Society to the Council for approval. Such a program should include projects of long and short duration to increase the public esteem of the medical profession in Illinois." This it is doing.

On Aug. 20, 1960, the committee submitted its first report to the Council calling for a strengthening of communications between the State Society and individual physicians, county societies, the press, and the community. To accomplish this the Committee offered a number of recommendations including the monthly publication of a colorful, news-style bulletin for distribution to all members. The first issue of "The Pulse" was mailed early in November.

Other recommendations of the committee call for annual district or regional meetings in an increased attempt to communicate with the "grass roots" of the Society; personal visits by the staff to county society meetings; the development of better working relations with the press; the development of community health education programs utilizing all the various media of communication; the cultivation of close liaison and working relationships with other professional and vocational groups; and the development of material to assist the individual physician in achieving improved client relationships.

To expedite the work of the new Committee on Public Relations, the Council has authorized the appointment of five sub-committees, each with specific public relations responsibilities. These sub-committees are: *Audio-Visual, Media Relations, Community Relations, Member Relations,* and *Group Liaison.* This arrangement will permit a broader base of member-participation in the challenging work of the Committee, in addition to increasing its total work-product.

Projects now in varying stages of development include radio and television series, newspaper articles on health problems and the work of organized medicine, exhibits depicting medical progress and the activities of the Society, a model press code for county society implementation, a public opinion survey, a color movie showing the contributions physicians voluntarily make to society through their county and state medical societies, a handbook on selected public relations projects basic to every county society, a series of pamphlets for physicians' waiting rooms, a stepped-up career recruitment program in cooperation with the Woman's Auxiliary, an annual community service program to be conducted simultaneously in each county and focusing attention on medical progress in the community — and other programs.

The Committee on Public Relations is sparing no effort in its attempt to project to the public the true image of the Illinois medical profession.

Publications and Scientific Activities

Another staff department made possible by the increase in dues is the Division of Publications and Scientific Activities. In addition to serving the large number of scientific sections of the Society, this division has administrative responsibility for the postgraduate medical education program, the publication of the Illinois Medical Journal, and the myriad of details attendant to the annual meeting. In each of these areas plans are under way that will result in increased services to members.

A state as large and influential as Illinois should have a medical journal second to none in the nation. The fact is that members want —and deserve—such a publication. Efforts are being made for the immediate improvement of the Journal in line with suggestions received from physicians throughout Illinois. In addition to higher scientific and editorial quality, the Journal will undergo a modernization of format, typography, and general appearance. A number of improvements have already been accomplished.

The director of publications, as a specialist in printing and publications methods, will also oversee all other printing for the Society as a means of obtaining the necessary quality at the most economical level.

Changes already made have reduced duplicating and printing costs on some jobs as much as 50 per cent. Further changes are expected to produce significant reductions in budgets while providing expansion of printing activity.

Undoubtedly the largest single project of the Society is its annual meeting. With a full-time staff man available to coordinate the many activities and implement the programs of the committees, considerably less time will have to be expended on the part of the dozens of physicians who have contributed their services to this in the past. Furthermore, it will now be possible to maintain a continuing liaison with the many hotels, exhibitors, and service firms which are a part of a convention.

The constant advances in medical sciences, and the refinements of surgical and medical techniques, all serve to emphasize the importance to the physician and the public of a high quality postgraduate education program. In addition to its continuing program of providing a ready source of scientific speakers for county medical society meetings, the Society can offer to members other avenues for keeping abreast of the latest developments in all branches of medicine.

Medical Service and Economic Research

The Society now has a professionally-staffed division devoted to solving problems of medical care of the needy, prepayment plans, and the general economics of medical practice. From this division members will receive services, both direct and indirect, that are available from only a few other major state medical societies.

The events of the past year, witnessed by Congressional passage of the Mills-Kerr Bill and the near passage of a Forand-type measure, point up the importance of having at our disposal accurate facts and figures relating to the cost of medical care, extent of the need, etc. In addition, the growing number of third-party arrangements that affect the medical profession demand constant attention and observation.

The implementation of the Mills-Kerr legislation in Illinois will be handled through this new division. The importance of this legislation, endorsed by organized medicine, was underscored at the December, 1960, meeting of the A.M.A., when the House of Delegates adopted a strongly worded resolution urging the earliest possible implementation of the Mills-Kerr Bill by every state in the nation.

Other programs of committees serviced by this staff division include the possibility of a relative-value study in Illinois, extension of liaison with the Illinois Public Aid Commission, and a number of research projects that may have significance to future medical practice.

Legislative Activities

Additional funds provided by the dues increase will enable the Division of Legislative Activities to expand its vital program of safeguarding the health of our citizens through sponsoring sound legislation and opposing measures detrimental to the interests of high quality medical care.

The Society now has a full-time staff legal counsel to direct the legislative program of the Committee on Medical Service. This assures that adequate time will be devoted to legislative research, bill drafting, and surveillance of measures bearing directly or indirectly on the free enterprise practice of medicine. Each session of the Illinois Legislature sees the introduction of thousands of pieces of legislation; some of these are of vital interest to the future of medicine, while others bear only a remote connection. Nevertheless, each must be studied for its possible effect on Illinois medical practice.

In an effort to improve the State Society's legislative communications with the profession, the *Springfield Newsletter* is now being sent to all members. It is hoped that this will stimulate grass-roots interest in the important legislative program of the Society, as well as keep members informed of vital legislation.

With a full-time staff legal counsel and the assistance of additional staff personnel the Springfield Regional Office will be able to handle promptly the increasing number of requests from county societies for legal opinions on such matters as medical licensure, staff requirements for hospitals, county society membership problems, and third party arrangements.

Administration

The foregoing report on new or increased services that will result from the 1961 dues structure is in addition to the administrative improvements detailed in my first report, published in the August, 1960, issue of the Journal.

The business affairs of an organization the size and stature of the Illinois State Medical Society require skilled attention if there is to be efficiency of operation. It is the responsibility of the Executive Administrator to make certain that members receive full value from their dues through the application of business-like methods and planning.

In large measure, this report reflects the progress and planning of the new staff, working through their various committees. Reports on these activities are made regularly to the Council, under whose supervision the staff and their assigned committees function. By the time of the 1961 meeting of the House of Delegates, I am confident that these services will merit your enthusiastic support of the dues increase.

Medical Testimony

Illinois Supreme Court Considering Procedure Rule To Use Impartial Witness Panels

The Supreme Court of Illinois is expected soon to promulgate a rule establishing a procedure for the use of impartial medical testimony, similar to Rule 20 of the United States District Court for the Northern District of Illinois. The Illinois Judicial Conference favored an impartial medical witness system at its annual meeting last June, and voted a resolution requesting the Supreme Court to adopt a rule.

The Illinois State Medical Society has established and certified panels of physicians, including specialists in various fields, who would be used as the impartial witnesses. There are 146 members covering 21 specialties. Dr. Samuel A. Levinson, of the University of Illinois College of Medicine and Chairman of the Society's Impartial Medical Testimony Committee, spoke before the Conference urging adoption of the system. The outline of his remarks follows:

The physicians of the State of Illinois feel that they are deeply involved in the proper and efficient resolution of personal injury cases. Therefore, in view of the burdensome case backlog:

I

We respectively recommend that regular meetings be held between a committee of the Judicial Conference of the State of Illinois and the Illinois State Medical Society beginning now. The Illinois State Medical Society has spent over two years studying and investigating impartial medical testimony. We feel that impartial medical testimony will be of material aid in your court in selected cases. We are ready to meet with you to share our investigative findings and to explore plans for its utilization.

II

We respectively recommend that the Judicial Conference of Illinois (or any part of it) adopt Rule 20 (of the U.S. District Court) now. Your court has the inherent power to adopt a rule and appoint neutral competent medical experts.

The Illinois State Medical Society has available panels of physicians throughout the state in several specialties and general practice. We are ready to help you.

Where impartial medical testimony is used, experience elsewhere discloses that 50 per cent of the cases should be settled by examination and report only. Twenty-five per cent more of the cases should be settled short of verdict or judgment by jury. About 11 per cent of cases will require the appearance of the panel expert in court as a witness and he may be examined and cross-examined by plaintiff's and defendant's lawyer in court just the same as any other witness. Either the plaintiff or defendant may call other medical witnesses in rebuttal.

III

We respectively recommend that you use impartial medical testimony in pre-trial cases now. This is based upon experience here and in other jurisdictions. The machinery is set up and ready to go. All that is necessary is to put it into operation.

Rule 20 of the U. S. District Court for the Northern District of Illinois follows:

Rule 20: Impartial Medical Testimony.

(a) Prior to the date set for the commencement of the trial of any personal injury suit, an examination (physical, medical, psychiatric, either or all) of the injured person, together with a report thereon, by an impartial medical expert or experts may be ordered—

(1) By a judge on his own motion, or

(2) On the motion of counsel for either party after a hearing is requested, if, in the judgment of the court such an order will be in the interest of justice and will materially aid in the just determination of the cause. The granting or withholding of such an order shall be entirely discretionary with the court. A copy of the report of examination shall be given to the court and to the attorneys for the respective parties.

Should the judge, at any time during the trial of the cause, consider it advisable, he may, in his discretion, and on his own motion, order such an examination and report.

Any examination ordered shall be made by a member or members of a panel of examining physicians designated for his or their particular qualifications by the Illinois State Medical Society after consultation with the court.

(b) At the termination of the case in this

Reprinted from the Illinois Courts Bulletin, Nov. 1, 1960.

court, the trial judge shall fix the compensation of the expert or experts and, unless otherwise directed by the court, such compensation shall be taxed as costs and paid by order of court. The judge, in his discretion, may direct that the parties, or either of them, deposit with the clerk of the court security in a specified amount which may be used for the payment of such compensation.

(c) In the event that the case shall go to trial after such examination and report have been made, or that trial shall be resumed, then either party or the court may call the examining physician or physicians to testify, in which event additional compensation may be allowed and taxed as costs as aforesaid.

Illinois State Medical Society Luncheon at the AMA Clinical Meeting, Washington, D.C., November 28





Above: Left to right are Council Chairman Edward A. Piszczek, alternate delegate, Chicago; E. Vincent Askey, president of the AMA, Los Angeles; Joseph T. O'Neill, past president ISMS, Ottawa, and H. Close Hesseltine, president of the ISMS, Chicago. Right: Ralph W. Neill, executive secretary, Washington State; Shelby Jared, delegate, Seattle; Percy E. Hopkins, delegate, Chicago.





Above: Left to right are William Challman, guest, Mt. Vernon, Ind.; Mrs. Frank Tao and Mr. Tao, press attache, Chinese Embassy, and Edwin S. Hamilton, president elect, Kankakee. Right: Left to right are Walter C. Bornemeier, delegate, Chicago; Eugene P. McEnery, alternate delegate, Chicago; Lester S. Reavley, past president ISMS, Sterling; Dr. O'Neill; Edward Cannady, East St. Louis, alternate delegate and Chairman, Illinois Committee on Aging, a special session on the White House Conference, and Peter F. Mack, Jr., Congressman, 21st District, Ill., Carlinville.

EDITORIALS

Hazards in disposable hospital equipment

We have been warned by the National Association of Central Supply Personnel that disposable hospital equipment is a health hazard unless properly sterilized. Included are plastic hypodermic syringes, tubing, and other equipment that is made by manufacturers with no prior experience in meeting the rigid standards of sterilization. They recommend that the hospital continue to assume the responsibility for safety and insist on adequate testing of these ready-to-use products before they are purchased. On this we agree.

This warning came on the heels of a letter to the editor concerning the disposal of used disposable needles and syringes. This writer had been on Chicago's Maxwell Street and found a vendor selling these items for a few cents. He claimed that the material had been found in the discarded trash of a hospital or physician's office. The vendor claimed he had nothing to hide and asked no questions from his buyers. They might be of value to diabetics, physicians, addicts, or perhaps to mechanics who wanted a unique oiler.

Contact lenses

The introduction, during the last decade, of plastic contact lenses covering only portions of the cornea has caused a profound change in the general attitude of the public toward contact lenses. The new type of lenses has been accepted and is worn successfully by a larger section of the population than was any of the older types. The new lenses owe their greater popularity to the greater comfort and longer wearing time they afford.

The many thousands of patient-hours during which the new lenses are worn have provided new opportunities for the recognition and observation of the undesirable, unfavorable effects of contact lenses upon corneal metabolism. These manifest themselves most conspicuously in the corneal epithelium, first as irregularities ("stippling") and later as actual desquamation (abrasion).

Either may happen with improperly fitted lenses, particularly if they press unduly against the center or any other part of the cornea. Such pressure may cause temporary corneal anesthesia so that the patient may not become aware of any corneal damage until several hours after the lens has been removed. These patients may go to bed with perfectly comfortable eyes and awaken several hours later with intense foreign body sensation and pain.

Even properly fitted contact lenses may disturb corneal metabolism seriously if the wearer's individual tolerance is exceeded. This tolerance varies greatly from one individual to another but can usually be built up by a process of gradual, systematic lengthening of the daily wearing time.

Both epithelial irregularities and abrasions may become the portal of entry for bacterial invaders. Catastrophic outcomes of such infections have been extremely rare, thanks largely to the effectiveness of antibiotics. In some patients corneal abrasions do not turn into ulcers because the patient is immune to the bacterial flora prevailing in his own conjunctival sac.

The technique of inserting and removing one's own lenses atraumatically is rapidly mastered by most individuals; therefore direct injury to the cornea by the edge of the lens, except during the very beginning of the indoctrination period, is infrequent.

All forms of corneal damage due to contact lenses are more apt to be serious in eyes with pre-existing corneal disease.

Despite all the progress in lens-designing and lens-fitting made during the last decade, the wearer of contact lenses still needs regular check-ups with special attention to the condition of his

cornea toward the end of his usual wearing period. For such check-ups the illumination and magnification provided by the biomicroscope are indispensable. If epithelial irregularites are detected, a slight change in the design of the lens or in the wearing schedule often suffices to make the lens safe and comfortable for a major portion of the wearer's waking hours.

Your committee on eye health is asking for your cooperation in the counseling and guidance of present and prospective contact-lens wearers in your community.

The Eye Health Committee
M. Byron Weisbaum, M.D.
Chairman
Peter C. Kronfeld, M.D.
Frank W. Newell, M.D.
Manuel L. Stillerman, M.D.

Conference on Federal-State medical program for the aged

"Complete medical care for those who need help." This theme was hammered home time and time again at this Conference, contrasting it to the Forand type of care for the aged. The first premise is the thought of the physicians of America expressed through the American Medical Association, as opposed to the inclusion of such care under a social security arrangement. The latter is tempting, but a moment's thought should assure us that if this is ever brought into usage, many would pay who would not get the service.

All day Sunday, November 27, was spent in conference at Washington's Sheraton-Park Hotel, learning the details of the new Mills-Kerr bill known as No. 778 of the 86th Congress. The AMA's Council on Medical Service did a real service for the profession when it brought together two distinguished panels to discuss during morning and afternoon sessions what is now being offered to those who need help, in addition to the old age assistance programs in operation in most states.

Under chairmanship of Dr. J. Lafe Ludwig of California, Dr. Russell B. Roth, who is chairman of the AMA Committee on Federal Medical Services, served as moderator of a panel consisting of Mr. C. Joseph Stetler, who gave the high points of the new law; Mr. William L. Mitchell, Commissioner of Social Security Administration in the Department of Health, Education and Welfare, and Dr. Ernest B. Howard, assistant executive vice president of the AMA. Mr. Mitchell gave an analysis of what can and what cannot be done under the Mills-Kerr law. Admittedly, he pointed out, the policies of the government will have some flexibility to allow for the different approaches various states will make in complying with the law. The law is a grant-in-aid provision in which individual states will put up 50 per cent, matched by a like amount from the Federal government, for the *better* care of the needy in the over-65 age bracket. The idea is not to supplant old age assistance, but to supplement such assistance so the worthy recipients will receive more adequate care.

Dr. Howard made clear the position of the AMA. The area of responsibility should be well delineated. The profession feels, as expressed through the AMA, that the welfare of an individual is his own responsibility. If for some reason he cannot meet this responsibility because of prolonged illness, unforeseen misfortune, or the like, he should look to his immediate family for aid. When he fails to receive help from this resource, the community, then the state, and finally Federal assistance may be invoked.

The opponents, those who look forward to bigger and bigger governmental activity, a la Forand, would put the entire burden under social security on the theory that all of those over 65 are poverty stricken. Embracing that thought, paraphrasing Dr. Howard, they would indeed be poor in purpose as well as purse. Such a philosophy is, in short, a system by which current workers are taxed to buy benefits for another group in whom they have no interest.

The afternoon session was moderated by Dr. John Flack Burton, chairman of the Committee on Indigent Care of the AMA. At this time, the policies recommended by the AMA for the guidance of the state associations looking toward the care of the indigent were reviewed by Dr. Wesley W. Hall. Following this review, four state representatives and three private underwriters presented varying methods of caring for older age groups.

In outlining the scope of services, Dr. Hall said, "Eligibility standards for medical assistance for the aged should be based on the individual applicant's medical needs and his ability to pay for care at the time of his need for such

care, without using up the resources he needs to retain his self-supporting status when he gets well."

The states, reporting their methods of handling the indigent sick, presented several viewpoints. Florida, for instance, maintains a deep sense of professional responsibility for these unfortunates. Under its program, which is supervised by the State Board of Health, a needy sick person is given medical care according to the nature of his illness and not according to the category of his indigency. They have had in operation a plan which not only provides short term hospital care for the needy sick of all ages, but they have authority to expand services to include outpatient care, visiting nurses, and drugs.

The Illinois plan of caring for the aged operates under the authority of the Illinois Public Aid Commission. The method was outlined in detail by Dr. Burtis E. Montgomery, past chairman of the Medical Advisory Committee. The charge given to the Illinois Public Aid Commission (a voluntary, non-salaried group) by the Public Assistance Code of the state was to ". . . establish such standards of assistance and service that applicants and recipients may maintain a decent and healthful standard of living. . . ." This they have done in a comprehensive manner. Payment is authorized, in the operation of the plan, for physicians' services and hospitalization including outpatient clinic care, nursing care at home or in institutions, and drugs, dental services, optical supplies, and such appliances as braces and crutches.

As evidence that they have discharged their duties well in Illinois, the Illinois Public Aid Commission had this to say in one of their publications: "By giving medical care to each person who has come to them for help, and by participating in the formation and control of the medical assistance program, as evidenced by their service on medical advisory committees, the physicians in Illinois have made a great contribution to the health and welfare of their fellow citizens. The Illinois Public Aid Commission acknowledges this professional service as outstanding." This is sufficient testimony that we can well be proud of Illinois' record in this most difficult of welfare areas. With this record established, Illinois will be able to implement the Mills-Kerr law though this establishment agency with a minimum of adjustment.

Summary — The Mills-Kerr law No. 86778 will be put in operation in all states cooperating with its provisions. Required is a legislative enactment setting up an agency with proper regulations for administration, the establishment of a minimum financial resource of the beneficiary (means test), and satisfactory working arrangement with the vendor of medical services. Medical service in this instance means professional, hospital, para-medical, and suppliers of medical goods and equipment. The thought is expressed that the medical profession must exert every effort to make this law succeed satisfactorily. At the same time we must continue our concern that Federal control of the profession will reduce the quality of medical care.

Dr. Shelby Jared, medical director of the Kings County Medical Service Group in Seattle, Washington, expressed such concern when he stated, in discussing their plan: "The nursing home problem is serious. These homes report that some families seem to forget 'grandpa' and 'grandma.' Visits from the family become more infrequent as the months of confinement lengthen. Children no longer feel obliged to provide protection and support for their parents. Such it seems is the end result when a government, state or otherwise, assumes total responsibility for its older citizens."

H. Kenneth Scatliff, M.D.

Whom do you consult in laboratory medicine?

The practice of medicine in Illinois has now been invaded by out-of-state air mail order commercial laboratories offering low fees for single tests and blanket fees if you send them all of your laboratory procedure consultations.

Investigation of one such laboratory revealed an Illinois "branch office" to be a "mail drop," and telephone calls were answered by a recorded message. Licensure of this laboratory was deferred since the premises could not be inspected.

You may have been misled since the advertising of such laboratories has appeared in medical society publications because of improper screening procedures by persons accepting such advertising for these publications.

The practice of laboratory medicine (pathology) is the practice of medicine according to

resolutions of the American Medical Association and our own State Society. As partners in the care of patients, the practitioners of laboratory medicine should be directors of such services if the patient is to be adequately served. Ethical practitioners of medicine do not offer cut-rate fees or the possibility of "kick-backs" or split fees. Proper results of laboratory tests cannot be obtained on specimens several days old.

Do you want to give the best to your patients: a careful history, a complete physical examination, the best laboratory studies?

OR — do you refer your deliveries to a midwife, your surgery to a surgical technician, that skin rash to the corner patent medicine counter?

Doctor, whom do you consult in laboratory medicine?

Paul A. Van Pernis, M.D.
President
Illinois Society of Pathologists

The Lake County Medical Society met on November 15, 1960 and adopted the following resolution during the regular business meeting. RESOLVED, That the practice of laboratory medicine including hematology, urinalysis, microbiology, clinical biochemistry, serology, immuno-hematology, blood banking, diagnostic radioisotopes and related procedures be considered the practice of medicine and that such procedures should be performed under the direction and supervision of a physician licensed in the State of Illinois.

It was further moved, seconded and the motion carried that the resolution be sent to the Council of the Illinois State Medical Society for its consideration.

Howard N. Schulz
Executive Secretary

This resolution was presented to the Illinois State Medical Society Council on Sunday, December 11, and approved in principle. It was referred to the Society's general legal counsel and the Medical Services Committee for further study.

Men are often capable of greater things than they perform. They are sent into the world with bills of credit, and seldom draw to their full extent. — *Walpole*

Births in Illinois, 1959

Illinois natality statistics for 1959, recently released by the state Department of Public Health, set several state records:

- the largest number of live births—239,871.
- the largest proportion of births in hospitals —98 per cent.
- lowest fetal death rate—14.5 per 1,000 live births.
- the largest number of premature births and highest rate.

The live birth rate was 24.2 per 1,000 population, only .3 below the highest recorded rate in 1957. Three counties recorded less than 90 per cent of births in hospitals: Alexander, 81.56 per cent; Gallatin, 88.98; Pulaski, 73.97.

Correspondence

Dear Dr. Van Dellen:

Enclosed are some "comments" about the editorial "Criminal Abortionist" which appeared in the Illinois State Medical Journal recently and about which I spoke to you in Washington, D.C.

It occurred to me that your editorial, because of its brevity, lent too much to misunderstanding.

Sincerely
H. Close Hesseltine, M.D.
President
Illinois State Medical Society

Criminal Abortionist

H. Close Hesseltine, M.D.

An editorial appeared in the Illinois Medical Journal, November, 1960, Volume 118, page 308, under the title of "Criminal Abortionists." The writer, undoubtedly, meant well by this presentation; but it is anticipated that readers will misinterpret or misunderstand the intent and purpose as well as difference between the legal and the theoretical aspects.

Reference in the second paragraph implied that the majority of performers of criminal abortions were doctors and that they were not members of the medical society. As a matter of fact, there are no reliable data on abortionists. From time to time, abortionists have been ex-

posed and some convicted. Some of these are mid-wives; some are merely technical assistants in one or another areas in the medical sciences; some are would-be practitioners of medical arts; and, occasionally, a physician. As a rule, these physicians do not belong to organized medicine. The record is that medical societies act decisively in removing any member who is unethical or criminal.

It is not only the right but also the duty of all citizens to expose any dishonest or criminal person or persons. In a theoretically ideal society, there would be no need for police, investigators, army or navy. Even though our civilization has advanced and improved itself, it still has imperfect members. These "defectors" do not conform to the rules and regulations of our society, and some brazenly commit criminal acts. Criminal abortion is, by law, illegal; by medicine, unethical; and, by religion, immoral. Any individual who performs, aids, refers, or contributes to this action is guilty of the crime (morally and legally).

In the first paragraph, reference was made that "the police know who the abortionists are but can seldom get sufficient evidence to lead to conviction." This statement must refer to the investigating force and not a generalization. It is possible that in a large police force of several thousand that a few policemen may have some knowledge of an abortionist; but it must be admitted that the great majority of the police are law-abiding citizens and, faithfully and honorably, fulfill their duties.

There is no accurate information about the number of criminal abortions performed any place in this country. Whatever the facts are, far fewer women die today because of criminal abortion. Even so, observations reveal that many women have physical or mental residual damage, perhaps both, of varying degrees after this illegal procedure.

This editorial stated also that a demand exists for the services of an abortionist. A demand exists for drugs for addicts and alcohol for alcoholics as well as for the activities of illegal and criminal acts. It is fair to state that any physician who does criminal abortions must have a psychopathic personality or be a psychopathic individual because this procedure is in frank conflict with the training and disciplines of medical science. It is the duty and responsibility of physicians to save or to prolong lives, to rehabilitate people, and to make their lives more comfortable and useful.

It is reported that abortionists, after learning who the individual's personal physician is, will say that the latter refers patients to him. Thus, totally innocent and strictly ethical physicians have been lied about and then had their reputations endangered. Some reasons for this deliberate lie may be that the criminal abortionist seeks status, wants dignity, and desires recognition or that he is also trying to "cover-up." Therefore, the members of the medical profession, if for no other reasons, have personal, as well as legal, desires to permanetly eliminate all abortionists.

Dear Mr. Boeck:

Thank you for your letter of October 17 attaching a copy of the *Springfield Newsletter,* dated October 10.

The Department Committee for Promotion of the Public Welfare Building Bond Issue appreciates very much the assistance your Society has rendered in behalf of this important issue.

We all look forward to success on November 8.

Sincerely yours,
Leonard E. Belt
General Chairman
Department Bond
Issue Committee

Dear Dr. Hesseltine:

Please accept the gratitude of the Board of Public Welfare Commissioners for your support and work on behalf of the Public Welfare Building Bond Issue. The efforts of your organization were largely instrumental in the success of the issue and should be acknowledged by every citizen in this state.

Thank you again for your very real help, and congratulations on a victory won in which you most definitely share.

Sincerely yours,
Frederick W. Slobe, M.D.
Chairman
Board of Welfare Commissioners

AT THE EDITOR'S DESK



Pharmaceuticals

It is known that vitamin B_{12} is poorly absorbed from the intestines of patients with pernicious anemia, sprue, and allied conditions. This has been tested repeatedly by tagging the vitamin with Co^{57} and determining its fate by doing radioactive studies on the urine. In the normal individual large amounts are recovered in urine, demonstrating adequate absorption. This is not true with the victim of pernicious anemia.

Racobalamin-57 is Abbott's new radioactive vitamin B_{12}. The isotope is available in solution or capsule form for the diagnosis of pernicious anemia by the Schilling test. When Co^{57} is given, the urine is tested several hours later for radioactive B_{12} by means of a scintillation detector.

Studies have shown that urinary output is less than 4 or 5 per cent in pernicious anemia, sprue, and other allied conditions. An output of 10 to 12 per cent definitely rules out the condition.

A differentiation between pernicious anemia and malabsorption due to other causes must be made when the output is in the 0 to 4 per cent range.

Racobalamin-57 Diagnostic Anemia Kits are available from Abbott Laboratories, Oak Ridge, Tenn., or from any of Abbott's 22 domestic branches which teletype orders to Oak Ridge.

Sterile Tape for Sterilizing

The Professional Tape Company of Riverside, Ill. has perfected a new tape to hold together bundles for sterilizing. The tape is unique, however, in that the word sterile appears on the surface after the package has been autoclaved at 250 F. for a period of 15 minutes. In other words, the tape acts not only as a fastener but as an indicator that the material has been subjected to a standard autoclaving cycle.

Diagnosing Auto-Accident Injuries

The examination of auto-accident victims requires an awareness of the possible injuries to the liver, spleen, bladder, kidneys, and the intestinal tract. According to Dr. James J. McCort of San Jose, California, laceration of the liver, for example, occurs in from 5 to 10 per cent of patients with abdominal trauma and is about one half as common as lacerations of the spleen.

He recently reported rupture or laceration of the liver by non-penetrating trauma among 26 accident victims. Twenty-one were in auto smash-ups. Twelve of the 26 showed fractures of the right lower ribs accompanied by contusion of the soft tissues, the pleura, and the lung.

PHS Takes Over Emergency Services

Responsibility for planning and operating the Nation's emergency medical stockpile program has been assumed by the Public Health Service.

The transfer of authority involves about $200 million worth of medical supplies and equipment located in 33 warehouses throughout the country. Included in the stockpile are 1,932 "packaged" 200-bed hospitals for civil defense emergency use, valued at $20,000 each. About 1,500 of these are now stored at strategic locations across the country and others are in use for demonstration purposes and for training personnel.

The Division of Health Mobilization is coordinating all mobilization preparedness activities assigned to the Public Health Service. Included in the division's programs are the development of an Emergency Health Service to function during a national emergency; training courses for medical and health-related professions; self-help procedures for individual survival; institution of an emergency water plan; research into standardized medical treatment procedures for use with austere resources; management of health

resources, including manpower, supplies, and facilities; assistance to governmental and nongovernmental agencies, states and local communities in developing disaster capabilities.

Polio Vaccinated Population

The Public Health Service reports that 93 million people under 60 years of age had at least one dose of polio vaccine. This represents 60 per cent of the population, an increase of 4 per cent over 1959. They estimate that 25 per cent of the population have now had four or more doses as compared to 14.2 per cent in 1959. About 45 per cent of persons 20 to 40 years of age are now fully vaccinated. On the other hand, 20 per cent of the children under five had no vaccine, and it is disturbing that so many babies and pre-school children remain unvaccinated.

More Pharmaceuticals

Elase is Park Davis' new enzyme product for the removal of debris from infected wounds. But the company is pointing Elase in the direction of cervicitis and vaginitis. These conditions accounted for 4.5 million visits made by women to physicians last year. The company claims beneficial results were obtained in 90 per cent of 129 patients suffering from cervical erosion, laceration, and cervicitis of various causes.

Cardioquin is a new quinidine alkaloid currently used for the treatment of cardiac arrhythmias. It is claimed to provide adequate therapeutic blood levels with a minimum of adverse side effects such as nausea and vomiting.

Antivert is a combination of meclizine and nicotinic acid. It is recommended by Rocrig as of value for vertigo. More recently, the combo was reported to produce a noteworthy reduction in the severity of headache in 72 of 134 patients. The headaches were of a wide variety of types.

Benzphetamine (Didrex) is Upjohn's new appetite suppressing drug. It is claimed that the product is "capable of helping the average overweight person lose more than a pound a week with no restrictions in diet and a minimum of side effects." Since the drug is an amphetamine, we wonder what Didrex has that the others don't. Oddly enough, the news release was based on a study in which nine of the patients complained of restlessness or loss of sleep which are the usual side reactions of this drug. In addition, the statement is made, "Dr. Rhoades' patients took the drug anywhere from 1 to 20 weeks, the average being 4.7 weeks. Of those continuing on Didrex, only three failed to lose weight." Since when are the results of a drug of this type evaluated only on the patients who continue to use it?

Changes in Death Rates

In studying the 1,656,814 deaths in the United States during 1959, the Public Health Service reports a rate of 9.4 per 1,000 — practically the same as for 1956, but 2 per cent lower than that of 1957, the year of the influenza epidemic.

Women continue to gain on men in life span. The rate per 1,000 population for white males decreased 0.9 per cent; for females, 1.1. Among nonwhites the rates for males decreased 2.6 per cent but among females 3.9.

Differences between death rates for whites and nonwhites have become smaller over the past decade. In 1950 the rate for white males was 15 per cent lower than for nonwhites; by 1959 the difference was 4 per cent. Among females, a difference of 24 per cent in 1950 had decreased to 9 per cent in 1959. While differences in death rate by sex in the white population increased only 1 per cent during the fifties, (36 to 37 per cent higher for men), for nonwhites differences in rates for men and women increased from a 26 to a 30 per cent higher rate for males.

Facts are often buried in figures, we are told. Some of these bear wider publication.

Heart and Lung Surgery Unit

The University of Chicago Medical Center has opened a 22-bed unit for heart and lung surgery patients. It is their opinion that patients requiring thoracic surgery need the benefit of every bit of specialization in this field. The unit will have its own treatment rooms, inter-com system between each bedside and the nursing station, and a triple oxygen and vacuum outlet next to each bed.

Physician-Patient Cardiac Intercom

A cardiac monitor that is fully transistorized has been developed by Westinghouse Electric. It indicates the heart rate on a dial and automatically sets off a high-pitched alarm signal if the pulse deviates or stops. It produces an audible "beep" during the normal heart beat. The unit features a radio transmitter capable of broadcasting an alarm signal to the physician who carries a receiver capable of handling alarms from one or more monitors. It can be heard up to a distance of two and one-half miles—a bit too far away in case the old heart decides to go into asystole.

Tender Nutrition

Dr. Ogden C. Johnson, assistant secretary of the AMA's Council on Foods and Nutrition, gave members of the National Live Stock and Meat Board a much needed boost. He told them that there was not yet sufficient clinical evidence to establish a relationship between diet and heart disease. It looks like we'll continue to have juicy steaks from those nice fat steers instead of tough stuff from lean and hungry range cattle.

"Bosom Beautifier"

A Hydro Massage was among the items seized last month by the FDA. A group from Oklahoma City claimed that it created "bosom beauty" by the elimination of waste material from the breast, assisting its chemistry to function normally. In addition, the device restored muscle and cell tissue circulation, thus lessening the chance of disease. The FDA probably had no trouble proving the claims for this one contrary to fact.

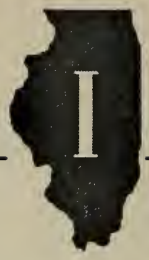
Most Laryngectomees Learn to Speak

Nine out of 10 persons who lose their voices because of cancer of the larynx learn to speak again. This new data became available through a survey of laryngectomees conducted by the American Cancer Society. Seventy-five per cent of the laryngectomees learn to speak again using esophageal voice exclusively. An additional 14 per cent talk with the aid of an electronic or mechanical larynx. The survey showed also that 11 per cent cannot talk at all, and approximately 70 per cent has a reduction in their incomes after surgery.

Management of infertility

One of the fallacies doggedly persisting in the management of infertility is the belief that vaginal secretions tend to be too acid and must be neutralized by alkaline douches. Another is that retroversion of the uterus is a common cause of infertility. A third outmoded view is that all infertile women require thyroid therapy in ascending doses to the point of intolerance. This last erroneous concept is responsible for the administration of 5 to 10 grains of thyroid extract daily to such unfortunate patients. Finally, it should be recognized that the probability of conception is not in direct ratio to the frequency of marital relations. Too frequent sexual intercourse during the seven to ten day period immediately after menses may exhaust the available supply of spermatozoa before arrival of the time most propitious for conception. *Robert B. Greenblatt, M.D. Infertility. Merck Sharp & Dohme Seminar Report. Winter 1960.*

ANNOUNCEMENTS



Mental Health Committee seminar

The Mental Health Committee of the Illinois Academy of General Practice will hold its third seminar-discussion course on Office Management of Emotional Disorders February through June from 10:30 a.m. to noon the first and third Wednesdays of the month. Meetings will be held at the Lutheran General Hospital, 1775 Dempster St., Park Ridge. The moderator will be Dr. Samuel Leibman, clinical assistant professor of psychiatry at the University of Illinois College of Medicine.

Registration fee of $30 is payable by check to the Illinois Academy of General Practice, 14 E. Jackson Blvd., Chicago 4.

PG course on fractures

The Philadelphia Regional Committee of Trauma of the American College of Surgeons will present a course in "Fractures and Other Trauma" March 2, 3, and 4 by Sir Reginald Watson-Jones of London, England. Others participating will be Dr. John Royal Moore, Philadelphia, and Dr. Preston Wade, New York. Registration is limited; the fee for the course is $50. For further information contact Dr. Lewis Manges, 2001 Delancey Place, Philadelphia 3.

Plan for nursing home accreditation

The American Nursing Home Association Accreditation Committee is working out details of a plan for accreditation of nursing homes to be set up on a nation-wide basis. The program, approved at the annual meeting in Washington, calls for a grouping of nursing homes into three categories: intensive care facility, intermediate care facility, and supervised-living care facility. It also envisions multi-level supervision arrangements at both state and regional levels of the association.

Dr. Elmer C. Kocovsky, Milwaukee, committee chairman, pointed out that the association accreditation program does not indicate any lack of interest in plans of the Tripartite Committee on Accreditation made up of representatives of the association, the American Hospital Association, and the American Medical Association.

Congress on maternal and infant health

The Fifth Illinois Congress of the Illinois Committee on Maternal and Infant Health will be held at the St. Nicholas Hotel in Springfield February 8 through 10. The committee is composed of representatives from obstetrics, gynecology, general practice, pediatrics, anesthesiology, nursing, public health, hospital administration, and social service.

The program will open with four luncheon conferences taking up "Staphylococcus Infections in the Newborn Nursery," "Regional Anesthesia in Obstetrics," and "Perinatal Mortality." Two panel discussions of interest to physicians and at 4:30 a series of round tables dealing with obstetrics and gynecology complete the first day's program.

Breakfast conferences at 7:30 Thursday morning will be followed by formal papers on "Hemolytic Disease of the Newborn" and "Extrauterine Pregnancy, Diagnosis, Dangers, and Therapy."

The remaining program is organized under this plan. There will be a total of 30 Breakfast Conferences, 8 Luncheon Conferences, and 45 round tables designed for maximum participation in group discussion. The Summation Lunch-

eon speaker Friday will be Robert A. Kimbrough, Jr., M.D., Cleveland.

Ophthalmology and otolaryngology meeting

The annual Spring meeting of the West Virginia Academy of Ophthalmology and Otolaryngology will be held April 6, 7, and 8 at the Greenbrier Hotel, White Sulphur Springs, with the following guest speakers:

Dr. Harvey E. Thorpe, Pittsburgh
- Recent Developments and Personal Experiences in Cataract Surgery
- Clinical Gonioscopy

Dr. John J. Shea, Memphis
- Fenestration of the Oval Window After Five Years
- Vein Graft Tympanoplasty

Dr. F. Johnson Putney, Philadelphia
- Laryngeal Keratosis: A Clinico-Pathologic Problem
- Neck Dissection in Cancer of the Larynx

Dr. Irving H. Leopold, Philadelphia, Titles to be announced.

Mr. Philip Salvatori of Obrig Laboratories will present an entire afternoon session on "The Contact Lens."

The registration fee is $25. For additional information write to the secretary, Dr. Worthy W. McKinney, 109 E. Main St., Beckley, W. Va.

Annual Bahamas Conferences

The seventh annual series of Bahamas Conferences in Nassau is offering a series of medical conferences on the following dates: Second Allergy Conference February 9 to 15; Eleventh Medical Conference April 3 to 15; and Conference on Internal Medicine April 30 to May 6.

The conferences offer an opportunity to combine a vacation with a good educational program. Nassau was chosen for these conferences for its climate, atmosphere, and geographic position.

The registration fee for each is $50.

Medico-legal institute

The Law-Medicine Center of Western Reserve University, Cleveland, has scheduled an institute on "The Skin: A Law-Medicine Problem" for February 17 and 18. Study by lecture and discussion of diseases and injuries of the skin is planned with emphasis on the medico-legal implications.

The tuition fee is $25. For further details contact Oliver Schroeder, Jr., The Law-Medicine Center, Western Reserve University, Cleveland 6.

Gill Memorial Hospital congress

The Gill Memorial Eye, Ear, and Throat Hospital, Roanoke, Va., will hold its annual spring Congress in Ophthalmology and Otolaryngology and Allied Specialties April 3 through April 8. There will be twenty guest speakers and fifty lectures.

Symposium on cancer research

The University of Texas M.D. Anderson Hospital and Tumor Institute will hold its annual symposium on fundamental cancer research February 23 through 25 in Houston. The Bertner Foundation Award will be presented for an outstanding contribution in the field of cancer research at the meeting, whose theme will be "The Molecular Basis of Neoplasia." The symposium will consist of 34 presentations by scientists from the United Kingdom, Austria, Israel, and the United States and will be devoted to nucleic acids, nucleic acids and proteins, mutation and protein structure, ribosomes and protein synthesis, controlling mechanisms and enzyme synthesis, and biochemical alterations induced by viral nucleic acids. For further information address the Publications Department, the University of Texas M.D. Anderson Hospital and Tumor Institute, Texas Medical Center, Houston 25.

Conference in ophthalmology

The Chicago Ophthalmological Society will hold its Annual Clinical Conference May 19 and 20 at the Drake Hotel in Chicago. According to the preliminary program, Dr. Harold G. Scheie, Philadelphia, will give the annual Gifford Memorial Lecture on May 19 at 5:15 p.m. Other speakers will include Count H. Arruga, Barcelona, Spain; Mr. G. Leigh, London, England; Dr. Bernard Becker, St. Louis; and Dr. Robert N. Shaffer, San Francisco.

Subjects of symposia include surgery and medical therapy of narrow and open angle glau-

coma and of secondary glaucoma, retinal detachment, and corneal surgery.

Registration fee for the course, including round table luncheons and dinner, is $45, payable to the Registrar: Mrs. Mary E. Ryan, 1150 North Lorel Avenue, Chicago 51.

Clinics for crippled children

February 1	Alton (Rheumatic Fever), Alton Memorial Hospital
February 1	Hinsdale, Hinsdale Sanitarium
February 1	Metropolis, Methodist Educational Building
February 2	Macomb, District Hospital
February 2	Litchfield, Madison Park School
February 3	Chicago Heights (Cardiac), St. James Hospital
February 8	Champaign-Urbana, McKinley Hospital
February 8	Rock Island (Cerebral Palsy), Foss Home
February 8	Springfield (Cerebral Palsy), Memorial Hospital
February 9	Anna, County Hospital District
February 9	Springfield, St. John's Hospital
February 10	Evanston, St. Francis Hospital
February 14	East St. Louis, St. Mary's Hospital
February 14	Peoria, Children's Hospital
February 15	Chicago Heights (General), St. James Hospital
February 16	Elmhurst (Cardiac), Memorial Hospital of DuPage County
February 16	Rockford, St. Anthony's Hospital
February 21	Belleville, St. Elizabeth's Hospital
February 22	Elgin, Sherman Hospital
February 23	Bloomington a.m. (General), p.m. (Cerebral Palsy), St. Joseph's Hospital
February 28	Effingham (Rheumatic Fever), St. Anthony's Memorial Hospital
February 28	Peoria, Children's Hospital

New Publication—*Chicago Medicine*

The Chicago Medical Society has ceased publication of the Chicago Medical Society Bulletin and is putting out Chicago Medicine in its stead. The first issue appeared on January 7. Dr. Harold Laufman, assistant professor of surgery, Northwestern University Medical School, is the managing editor, heading a staff of three. Changes in format from the older publication include new typography, a new cover design, more feature articles by Chicago physicians, more program listings, and more pages. The calendar will remain its most important feature, and it will still appear weekly.

It is the goal of Chicago Medicine to provide a forum for the closer communication of ideas between the members of the Chicago Medical Society and the city's great medical institutions.

Medicine on postage stamps

Recent issues of postage stamps of medical interest include the following:

Afghanistan: Two stamps mark the "Fight Against Malaria."

Austria: Dr. Anton Freiherr von Eiselsberg, Austrian neurosurgeon, is pictured on a stamp commemorating his one hundredth birthday anniversary.

Belgium: A 40c stamp in a series of eight marking the independence of the Congo has medical service as the subject.

Colombia: A 5c Red Cross stamp was obligatory on all mail in September.

Denmark: A 60c commemorative for the 10th Congress of the WHO Regional Committee in Copenhagen shows a mother with suckling child.

France: Six stamps with surcharges for the Red Cross includes one with portrait of Jean-Martin Charcot, French neurologist, and view of Saltpetriere Hospital, Paris.

Gabon: A 200f stamp honors Dr. Albert Schweitzer, Nobel Prize winner.

Haiti: The 1945 Red Cross stamp was overprinted twenty eighth anniversary and revalued.

Hungary: One of four stamps honoring famous men portrays Dr. Ignaz Semmelweis, pioneer in obstetrical antisepsis.

Iran: Three stamps commemorate the WHO anti-malaria campaign.

Israel: A 25c stamp honors Henrietta Szold, American-born founder of Hadassah, established to promote medical education and clinics; Hadassah Medical Center is shown in background.

Netherlands Antilles: Three values with surcharges were issued to "Help Fight Cancer."

Pakistan: Two stamps mark the centenary of the King Edward Medical College.

Philippines: Two stamps mark the fiftieth

anniversary of the Philippine Tuberculosis Society.

Poland: A 50gr stamp was issued for the fifth Pharmaceutical Congress in Warsaw.

Rumania: Stamps in a new 21-value definitive set include a 30b portraying medical assistance and a 2.40L honoring the pharmaceutical industry.

Siam: Two anti-leprosy stamps were issued.

Switzerland: Special stamps for various UN agencies operating in Geneva and Berne include pairs (30c and 50c) for the WHO.

Trinidad-Tobago: The General Hospital at San Fernando is shown on a 10c issue.

Turkey: Stamps commemorating the Manisa kermis (local saint day) include two showing the Manisa Lunatic Asylum.

Viet Nam (North): Two stamps commemorate the founding of the International Red Cross.

Viet Nam (South): A four-value Red Cross set features the portrait of Henri Dunant, Red Cross founder.

Yugoslavia: Two stamps were issued for the benefit of the Red Cross.

Make Sure You Are Represented

See That Your Delegate Attends . . .

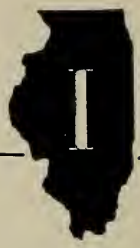
The 1961 Annual Meeting of the
Illinois State Medical Society
House of Delegates Meetings

Sunday, May 14 — 7:30 P.M.

Tuesday, May 16 — 7:30 P.M.

Thursday, May 18 — 9:00 A.M.

NEWS of the STATE



County

Champaign

Dr. Floyd Eugene Boys, Urbana, associate professor of health education, University of Illinois, recently became the new editor of the Bulletin of the Champaign County Medical Society. At the November meeting of the society the editors were commended on the bulletin's new format, general improvement, and use of original articles.

Cook

Dr. Masserman Gives Duff Memorial Address. Dr. Jules H. Masserman, professor of neurology and psychiatry, Northwestern University Medical School, presented the G. Lyman Duff Memorial Address at McGill University, Montreal, on December 6. Dr. Masserman spoke on "Anxiety and the Arts of Healing." His address began a lecture series he is giving at New York state universities and hospitals on psychotherapy and various aspects of research in psychiatry being conducted at Northwestern.

Dr. Harrison Addresses Heart Association. Dr. Tinsley R. Harrison, chairman of the department of medicine, Medical College of Alabama, was the speaker at the January 10 meeting of the Chicago Heart Association's fifth James B. Herrick Memorial Lecture in Chicago. His subject was "Movements of the Heart, Some Clinical and Physiological Considerations."

Honored. Three Chicago physicians were among those who received Founders' Day awards for outstanding examples of responsible citizenship to the present and future generations at the 90th anniversary convocation of Loyola University December 12. The physicians so honored were H. William Elghammer, chairman of pediatrics, for forty years of volunteer work on the faculty; John L. Keeley, chairman of surgery, for service to his medical specialty; and Harry A. Oberhelman, former chairman of surgery, for his dedication and inspiration as a teacher.

Gastroenterologists Elect Officers. Three Chicago doctors were elected officers of the American College of Gastroenterology at its annual meeting in October. They are Edward J. Krol, vice president; John P. Waitkus, trustee; and George J. Rukstinat, governor.

New Convalescent Home for Aged. The Homestead Convalescent Home, a modern, $650,000 one-story structure, was completed in Burnham in December. It accommodates 100 elderly persons in single, double, and triple rooms and has x-ray and therapy rooms, an electronic call for nurses, a two-way intercom system, and complete air conditioning and fireproofing. Dr. Louis J. Brody, Chicago physician and surgeon, is the medical director. Registered nurses on 24-hour duty, a physiotherapist, and an occupational therapist, are on the staff. Under the home's medical program the patient's own physician retains control of the case.

Dr. Adams Heads U. of C. Cancer Foundation. Dr. Wright R. Adams, professor and chairman of the department of medicine in the Division of the Biological Sciences, University of Chicago, was elected president of the University of Chicago Cancer Research Foundation at the December annual meeting. Dr. Adams has been

with the University of Chicago since 1930 and chairman of the department since 1949.

Dr. Gasul Honored. Dr. Benjamin M. Gasul, chief of the pediatric cardiac service, Cook County Hospital, was awarded $500 at a Salute to Research dinner of the Chicago Business and Professional Men's Chapter of the City of Hope in Durante, Calif. Dr. Gasul was honored for his investigation of diseases of the heart.

Promotions. Seven physicians on Northwestern University's Medical School faculty have been promoted to full professor. The promotions include Dr. Craig Borden, medicine; Dr. Hutton Slade, microbiology; Drs. John W. Huffman and Augusta Webster, obstetrics and gynecology; Dr. David Hsia, pediatrics; Dr. Irving Schulman, pediatrics; and Dr. Frederick Preston, surgery.

Dr. Orndoff Receives First Stritch Medal. Dr. Benjamin H. Orndoff, professor and chairman of radiology, Stritch School of Medicine, received the first Stritch Award Medal from Loyola University November 29 for his contributions to radiology and medical education in radiology. Dr. Orndoff joined the faculty of Loyola just before 1917, when it was still the Chicago College of Medicine. He helped found and became head of a full-fledged department of radiology and has been chairman ever since. In addition, he has been in private practice since 1930 and active in local, national, and international societies of his specialty.


Dr. Benjamin H. Orndoff

Appointed. Dr. Donald J. Ferguson has been appointed professor of surgery at the University of Chicago. He has been chief of the surgical service at the Minneapolis Veteran's Administration Hospital since 1954.

DuPage

The DuPage County Medical Society held an afternoon symposium on "Practical Medical and Surgical Clinical Endocrinology" January 18 in Lemont. The speakers were Dr. William C. Perkins, West Chicago; Dr. Isidore Snapper, director of medicine and medical education, Beth-El Hospital, New York, and Chicago physicians Louis D. Boshes, S. Howard Armstrong, Jr., and Joseph P. Evans.

Henry

The Henry County Medical Society in a November meeting in Kewanee elected Dr. Erwin Frankel, Toulon, president and re-elected Dr. Robert Younglove, Kewanee, secretary. Dr. H. Close Hesseltine, president of the Illinois State Medical Society, was the principal speaker at the meeting.

Madison

The Madison County Medical Society at its annual meeting in November adopted the following resolution presented by Dr. Harry Mantz:

Whereas the Illinois Public Aid Commission insists on the use of its own prescription forms which are wasteful of physicians' and pharmacists' time and the taxpayers' money.

Now therefore be it resolved that the House of Delegates of Illinois State Medical Society instruct its Medical Advisory Committee to the Illinois Public Aid Commission to officially oppose the use of these prescription forms.

St. Clair

Newly elected officers of the St. Clair County Medical Society are Dr. Charles H. Bauman, president; Dr. Lamar H. Ochs, re-elected secretary, and Mrs. Lois Morgan, executive secretary.

Whiteside

Dr. Rudolph Mrazek, assistant professor of surgery, University of Illinois, addressed the Whiteside County Medical Society December 15 in Sterling on "Current Status of Chemotherapy of Cancer and Allied Diseases." The appearance of Dr. Mrazek was arranged by the Postgraduate Medical Education and Scientific Service Committee of the Illinois State Medical Society at the request of Dr. Julius A. Kolis, program

chairman of the Whiteside County Medical Society.

General

Dr. Cole receives radiologists' gold medal

Dr. Warren H. Cole, professor and head of the department of surgery, University of Illinois College of Medicine, was awarded a gold medal by the Radiological Society of North America at its 46th annual meeting in December. He was honored as an "eminent scholar and researcher, distinguished surgeon, noted author and kindly teacher." Dr. Cole was also the 1960 Carman Lecturer for the society and presented a lecture on "Visualization of the Biliary Tract" preceding the medals awards. Dr. Cole is immediate past president of the American Cancer Society, 1955 president of the American College of Surgeons, and 1950 president of the Chicago Medical Society.

Delegates to conference on aging

Fifteen Illinois physicians were among the 100 delegates selected to represent Illinois at the White House Conference on Aging January 9 through 12. They were Otto L. Bettag, Springfield; Edward W. Cannady and J. W. Compton, East St. Louis; Preston V. Dilts and Leroy L. Fatherree, Springfield; Edward Gordon, John B. Hall, H. Close Hesseltine, and Leroy P. Levitt, Chicago; Joseph Mallary, Mattoon; Burtis E. Montgomery, Harrisburg; G. J. Pohly, Rock Falls; Henry T. Ricketts and Jack Weinberg, Chicago, and Henry Wilson, Peoria.

Final selection was made from over 1,000 men and women and included persons from big and little business, agriculture, labor, government, religion, education, architecture, health and welfare, civic, social, fraternal, and professional groups.

The conference was directed to solving the major problems confronting older people and to developing programs and policies that will make life better for the older people of the future.

The conference brought together 2,800 delegates, 1,747 of which represented states and territories. The balance included delegates from national organizations and national advisory committee members and consultants. The size of each state delegation was determined in proportion to state representation in the House of Representatives, with 100 the maximum for any one state. In addition to the 100 Illinois delegates, approximately 60 additional citizens of the state attended as national delegates, advisors, and consultants.

ACOG awards to two Chicago physicians

Two young Chicago physicians received awards for outstanding scientific studies at the annual meeting of District VI of the American College of Obstetricians and Gynecologists and its Junior Fellow Division. They were Dr. Philip Ricks, University of Illinois College of Medicine, first place, obstetrics, "Sickle Cell Anemia in Pregnancy," and Dr. Kurt Bockner, University of Illinois College of Medicine, second place, gynecology, "Cervical Cytological Screening Program at an Air Force Base." Prizes were $100 for first place and $50 for second.

Dr. Thomas J. McGrath, Cook County Hospital, was elected secretary of the district division, which includes seven states: Illinois, Iowa, Wisconsin, Minnesota, North and South Dakota, and Nebraska—and Manitoba and Saskatchewan, Canada.

Appointees to cancer and necropsy boards

Three members were reappointed in December to the Advisory Board of Cancer Control in the Illinois Department of Public Health for three-year terms expiring Sept. 1, 1963. Members named are Dr. Edwin F. Hirsch, Presbyterian-St. Luke's Hospital, Chicago; Dr. Charles L. Leonard, St. Anthony's Hospital, Rockford, and Dr. James M. Christie, Champaign.

Governor Stratton also named Dr. Jacob E. Reisch, Springfield, to the Advisory Board on Necropsy Service to Coroners. His term of office expires Nov. 1, 1963.

Southern Illinois physicians ok student loan fund

Members of the Southern Illinois Medical Association at a business meeting in November in

Murphysboro approved a plan to participate in the support of the student loan fund directed by the Illinois Agricultural Association. The need for such a plan was readily recognized by members of the association. For this purpose the association increased the amount of the annual dues by $1.

Advisory committee appointees

Ten physicians were among those appointed to an advisory committee named by Gov. Kerner to aid reorganization of the State Department of Public Welfare. They are Walter Baer, a Peoria psychiatrist; Ner Littner, Chicago, child psychiatrist; Jack Weinburg, University of Chicago psychiatrist; Fred Slobe, chairman of the Chicago Public Welfare Commission; John Madden, professor of psychiatry, Loyola University; C. Knight Aldrich, University of Chicago psychiatrist; F. Garm Norbury, Jacksonville, past president of the Illinois State Medical Society; Roy Grinker, psychiatrist at Michael Reese Hospital; Gerald O'Connor, president of the Illinois Association for Mental Health, and Nathaniel Apter, staff researcher at Manteno State Hospital.

Honor awards in medical journalism

Medical journals associated with Chicago were recipients of three of the four 1960 Honor Awards for Distinguished Service in Medical Journalism, presented by the American Medical Writers' Association.

The New Physician, published by the Student American Medical Association with editorial offices in Chicago, for general medical periodicals of more than 3,000 copies per issue. Mr. Russell F. Staudacher is editor; Miss Evelina T. Loke, managing editor.

Quarterly Bulletin of Northwestern University Medical School, for general medical periodicals of less than 3,000 copies per issue. Barry J. Anson, Ph.D., is editor; Miss Jane W. Bell, managing editor.

Cancer Research, published in Chicago, for medical periodicals devoted to some specialty in medicine or medical science. Dr. Harold P. Rusch, Madison, Wis., editor-in-chief.

Dr. Dean F. Smiley, Evanston, executive director, Education for Foreign Medical Graduates, received the 1960 Distinguished Service Award given to a fellow of the association. Dr. Lowell T. Coggeshall, vice president of the University of Chicago, was recipient of the Honor Award to non-members for leadership in medical research and administration, lucid writing of several hundred medical articles, and energetic editorial capacity.

The awards, each consisting of a plaque, were presented at the annual meeting of the Association November 18.

Deaths

Frank A. Anderson*, retired, Chicago, a graduate of the Chicago College of Medicine and Surgery in 1913, died December 1, aged 74. He was a founder and former director of Franklin Boulevard Hospital and a fellow of the American College of Surgeons. Dr. Anderson had practiced in Chicago for 33 years before his retirement.

Milton John Babcock*, Biggsville, a graduate of the Hahnemann Medical College and Hospital in 1906, died November 14, aged 88. He was the president of the Henderson County Medical Society and had practiced in Biggsville for 42 years.

Herman Chor*, Chicago, a graduate of the University of Maryland School of Medicine and College of Physicians and Surgeons, John's Hopkins University in 1934, died November 11, aged 56. Dr. Chor was on the staff of Wesley Memorial Hospital and an associate professor in the neurology and psychiatry department at Northwestern University Medical School. He was a Navy commander during World War II and was in charge of neuropsychiatry at the Pearl Harbor Hospital. He was the author of numerous articles in his field.

Laurence A. Dondanville*, Moline, a graduate of Northwestern University Medical School in 1924, died November 14, aged 69. Dr. Dondanville was a member and past president of the Rock Island Medical Society and was named "doctor of the year" by the organization in 1955. He was a member of the staffs of St. Anthony's and Moline Public hospitals and was past president of the latter. Dr. Dondanville had practiced in Moline for 35 years and was a member of

the Moline Elks, Moline American Legion Post 246, and was a 4th degree Knight of Columbus of Loras Council.

Ralph Falk, Chicago, a graduate of Jefferson Medical College, Philadelphia in 1907, died November 2, aged 76. In 1931 Dr. Falk and his brother founded Baxter Laboratories, in Morton Grove, and pioneered in the development of safe solutions for intravenous feeding. He was a surgeon in Boise, Idaho, for many years and served as secretary of the Idaho State Board of Health from 1910 to 1914. He was on the staffs of St. Alphonsus and St. Luke's hospitals in Boise for 32 years and county physician in Ada, Idaho, from 1909 to 1910. During World War I he was a captain in the U.S. Army Medical Corps. Dr. Falk was a fellow of the American College of Surgeons and a member of Sigma Phi Epsilon fraternity.

George Karl Fenn*, Chicago, a graduate of Northwestern University Medical School in 1913, died November 23, aged 70. Dr. Fenn was president of the Chicago Heart Association from 1947 through 1954 and a member of the association's board of governors for 24 years. He was also chief of staff at St. Luke's from 1943 until shortly before its merger in 1956 with Presbyterian Hospital and director of the electrocardiograph laboratory at Presbyterian-St. Luke's until he resigned in October because of ill health. Dr. Fenn began teaching at Northwestern University Medical School in 1920, became a professor in 1952, and professor emeritus in 1956.

Charles Arthur Fleischner, San Diego, a graduate of Loyola University in 1920, died October 21, aged 65. Dr. Fleischner was on the staff of Lutheran Deaconess Hospital in Chicago until 1943 and served with the U.S. Navy in World War II, attaining the rank of Commander. He had lived in San Diego since 1946.

Zoltan Galambos*, Chicago, a graduate of Univerzita Komenskeho Fakulta Lekarska, Bratislava, Czechoslovakia, in 1920, died November 2, aged 65. He was a past president of the staff of American Hospital and a member of the American Academy of Tuberculosis Physicians and the Trudeau Society. He came to this country from Hungary 36 years ago to practice medicine.

Leo Albert Goodman, Chicago Heights, a graduate of Northwestern University Medical School in 1910, died September 6, aged 73.

S. James Harbrecht*, Chicago, a graduate of St. Louis University School of Medicine in 1920, died November 5, aged 70. He was an associate staff member of Mercy Hospital and a courtesy staff member of St. Francis Hospital in Evanston. He was a member of the American Geriatrics Society and the Knights of the Order of St. Gregory the Great.

Leonard H. Harris*, Peoria, a graduate of the Northwestern University Medical School in 1933, died December 4, aged 55. He was formerly on the faculty of Northwestern University's Medical School and was a former president of the American Academy of Allergy. He had practiced in Peoria for 15 years and was a lieutenant commander in the Navy in World War II.

Victor J. Hays*, Chicago, a graduate of Rush Medical College in 1924, died November 2, aged 70. Dr. Hays had been a staff member at West Suburban Hospital for 35 years.

Ernst Herman Hoffman, Chicago, a graduate of Northwestern University Medical School in 1908, died November 10, aged 77. Dr. Hoffman was a member of the Christian Medical Association, the Chicago Medical Association, and the Wilson and Oaron Legion posts of Chicago. He served as a captain in the medical corps in World War I and then practiced in Chicago and Des Plaines.

Harry Jay Ireland*, Peoria, a graduate of Northwestern University Medical School in 1934, died August 26, aged 58. Dr. Ireland was past president of the staff of St. Francis Hospital in Peoria and was president of the Peoria County Medical Society at the time of his death. He was a consultant at the Peoria State Hospital, a fellow of the American College of Surgeons, and a veteran of World War II.

George E. Kirby*, Spring Valley, a graduate of the Jenner Medical College in 1915, died November 20, aged 74. He was chief surgeon at St. Margaret's Hospital in Spring Valley, vice president of the Illinois State Medical Society in 1952 and 1953, and past president of the Mississippi Valley Medical Society.

Dr. Kirby was a member of the Illinois Surgical Society, Illinois Society for Medical Research, American Geriatrics Society, Association of American Physicians and Surgeons, and the American Academy of General Practice. He was vice president of the Bureau County chapter of

the National Foundation for Infantile Paralysis for 20 years and was a Spring Valley public health officer. He was an honorary life member of the Spring Valley Rotary Club, a member of the Elks Lodge at Princeton, and a past president of the Hall high school board of education.

John Minton Mitchell, Evanston, a graduate of Northwestern University Medical School in 1916, died November 29, aged 73. Dr. Mitchell was on the staff of Evanston Hospital and had practiced in Evanston over 40 years. During World War I he was a captain in the Army medical corps.

Ross Lee Moter*, Albion, a graduate of Barnes Medical College, St. Louis, in 1904, died November 18, aged 80. He was on the staff of Wabash General Hospital and a 50-year member of the Hermitage Masonic Lodge at Albion.

P. Earl Rogers*, Aurora, a graduate of the Chicago College of Medicine and Surgery in 1916, died November 17, aged 70. He was on the staffs of Copley Memorial, St. Joseph Mercy, and St. Charles hospitals and served as a first lieutenant in World War I. He had practiced in Aurora for 44 years.

Robert C. Romano*, Chicago, a graduate of Stritch School of Medicine of Loyola University in 1948, died November 21, aged 35. Dr. Romano had been on the staff of Loretto Hospital. During World War II he served with the Navy Medical Corps.

Albert J. Schoenberg*, retired, Druid Hills, North Carolina, a graduate of the University of Illinois College of Medicine in 1899, died October 30, aged 89. Dr. Schoenberg was chief of staff of the old Evangelical Deaconess Hospital and on the staff of Augustana and Illinois Masonic hospitals. He had been an instructor of gynecology at the University of Illinois Medical School.

Chauncey E. Schuyler*, Harvard, a graduate of Stritch School of Medicine of Loyola in 1941, died November 27, aged 61. Dr. Schuyler also had a degree in dentistry from Loyola University School of Dentistry. He was on the staff of St. Luke's Hospital for a year before going to Denver, where he was a resident on the staff of St. Luke's Hospital. Fourteen years ago he returned to Harvard, when he was on the surgical staff at the Harvard Hospital and a health officer.

Herman M. Soloway*, Chicago, a graduate of the University of Illinois College of Medicine in 1922, died December 2, aged 68. Dr. Soloway was attending urologist at Cook County Hospital for 30 years. He was the State Public Health Department's first venereal disease control officer.

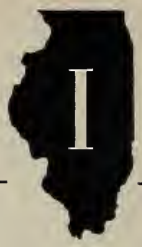
John B. Suino*, Peoria, a graduate of the Chicago Medical School in 1933, died July 29, aged 57. He had been medical director of the American Red Cross Center and was a veteran of World War II.

Carl F. Waters*, Elmwood Park, a graduate of the University of Illinois College of Medicine in 1932, died December 2, aged 55. He was a staff member of Oak Park, West Suburban, and Northwest hospitals.

William Yonker*, Chicago, a graduate of the University of Illinois College of Medicine in 1922, died August 18, aged 64. He was a veteran of World War II.

**Indicates member of the Illinois State Medical Society*

BOOK REVIEWS



Complications of Surgery and Their Management. Curtis P. Artz, M.D., and James D. Hardy, M.D. $23. Pp. 1075. Philadelphia and London, W. B. Saunders Company, 1960.

This large and unparalleled volume heralds the voice of a new generation in the literature of American surgery. Although many familiar, older names are present among the 71 contributors to this work, a host of newer surgeons has written a large portion of the text. Instructors, associates, and even one resident, Stuart Roberts of the University of Illinois, are represented here. Their contributions are refreshingly well done, concisely presented, and display amazing experience.

Half of the book is devoted to complications common to surgical therapy in general. Radiation therapy, spread of cancer, and anesthesia complications are included. Familiar contributors such as Claude S. Beck, Warren Cole, and James Hardy are well displayed, but outstanding chapters such as "Complications of Antibiotic Therapy" and "Infections in Surgery," the former by Edwin J. Pulaski and the latter by Curtis P. Artz, dominate this first portion of the book.

In the more specific chapters, such standard bearers as Frank Glenn (Biliary Tract), Arthur H. Blakemore (Portacaval and Splenorenal shunts), and Leo Zimmerman (Hernia Repair) along with Altemeir, Waugh, Clatworthy, and Zollinger carry the major load. Such pitfalls as repetition of common complications in each chapter, explication of technical procedures, and needless description of disease processes are avoided. Editing is good, errors are few, and a wealth of otherwise unavailable material is gathered and presented.

Criticism of such a first-rank work is difficult. Perhaps more illustrations would be helpful in breaking up the text, but this is a minor point. The book will be of great value to practicing surgeons, to residents in their senior year, and to surgical libraries. It should be required reading for today's busy, competent general surgeon.

John J. Bergan, M.D.

Factors Controlling Erythropoiesis. James W. Linman, M.D., and Frank H. Bethell, M.D. $8.25. Pp. 208. Springfield, Ill., Charles C Thomas, 1960.

It is generally agreed that humoral factors are of primary importance in the control of erythropoiesis. In this monograph the authors review and contribute experimental evidence for the existence of humoral erythropoietic factors; methods of demonstrating erythropoietic activity; and some of the chemical, physical, and physiological characteristics of the factors which govern erythropoiesis. The term "erythropoietin," first suggested by Bonsdorff and Jalavisto, has received wide acceptance as a designation for the humoral erythropoietic agent. The authors believe that there are at least two factors capable of stimulating erythropoiesis and prefer to call them "plasma erythropoietic factors." They state that one humoral factor augments hemoglobin production; a second humoral factor governs the mitotic activity of erythrocytic precursors. Experimental studies with butyl alcohol suggest that not only erythroid activity but all aspects of hematopoiesis are subject to humoral control. The authors document their contentions on the basis of their own, previously published laboratory studies as well as a thorough review of the literature. It must be pointed out, however, that some of their views are not subscribed to by all investigators in this field.

The chapters on the control and site(s) of production of the erythropoietic factor(s) are informative but also contain elements of specula-

tion. The final chapter on the role of the erythropoietic factors in man considers the apparent roles of the humoral factors in a variety of anemias, secondary polycythemia, and polycythemia vera. There is an exhaustive bibliography of 370 references.

In spite of some speculative and controversial aspects, this book is timely and presents a comprehensive picture regarding the present status of erythropoietic factors.

Louis R. Limarzi, M.D.

The Cigarette Habit — A Scientific Cure. Arthur King. $2. Pp. 96. New York, Doubleday & Company, 1959.

The monograph adds another reference to the growing bibliography on the relation of smoking and disease. The general habit of smoking tobacco is discussed, but most, if not all, of the specific points brought out refer to the smoking of cigarettes.

Having failed at one attempt to break the cigarette habit, the author busied himself in an analysis of this habit. He immediately became impressed by the similarity of his symptoms on trying to break the cigarette habit to those addicts' experience on the withdrawal from alcohol or narcotics. Further research led him to the opinion that in some persons addiction did, in fact, occur. This led him to develop a method for quitting the cigarette habit that could be used by virtually all its victims.

Smokers are classified into four categories:

(a) The light smoker (5% of victims) consumes less than a pack of cigarettes a day, enjoys the mechanical features of the habit as much or more than the actual smoking. The majority of pipe and cigar smokers are thus catalogued.

(b) The medium smoker, who makes up some 45 per cent of the cigarette smokers, consumes one pack of cigarettes per day on the average. He smokes rather steadily, except for occasional periods of excess when he usually realizes that the practice might be injurious. Periodically he quits smoking, often merely to prove his ability to do so; yet with like consistency he returns to the habit.

(c) The heavy smoker (40% of victims) generally consumes more than one pack of cigarettes a day. Smoking bothers him frequently, and he often considers quitting. When he does quit, it usually becomes an ordeal, and he returns to his habit and accepts its penalties rather than the torments of quitting.

(d) To qualify as a cigarette addict, (10% of victims) the quantity of tobacco consumed is not the only measure. Smoking is an integral part of this person's daily pattern. He enjoys it and continues to smoke in spite of its ill effects on him. He cannot even bear the thought of quitting. He is, in fact, addicted.

The procedure of quitting can hardly be summarized; the interested person should refer to the text where the program is detailed and elaborate.

It consists of various preparatory steps designed to put the victim in an appropriate frame of mind over a period of 21 days. This time will be used to decrease the cigarette enjoyment and thereby re-enforce the determination to quit.

The actual process of quitting is again enhanced by similar psychological maneuvers aided by medicaments and drugs such as caffeine and antihistamines. For cigarette addicts, dexedrine and phenobarbital are utilized in place of the latter. Again, this period requires twenty-one days, but can be passed through without serious withdrawal symptoms if all goes well.

The final chapter deals with the controversial aspects of the causal relation of cigarette smoking to disease, notably lung cancer.

It is interesting that the author should expend such effort in elaborating a plan for quitting cigarettes while saying that "except for a relatively few unfortunate smokers, who, . . . become just as addicted to cigarette smoking as do certain individuals become addicted to alcohol or drugs — tobacco smoking, including cigarette smoking, is a boon and not a threat to human life and society."

The effort may be justifiable, however, when he says "I know that many smokers who should quit will quit and that the vast majority of smokers can go back to smoking with a peace of mind they haven't enjoyed since the Great Lung Cancer Scare began."

From personal experience, as a reformed heavy smoker, (I did not quite check out as an addict) the key to success is a compelling reason for

quitting. I ceased abruptly. In retrospect, however, perhaps my own slow acceptance of the adequacy of the reason and the squirming maneuvers I used to escape the direct force of compulsion may have taken the place, quite by accident, of what author King proposes by intent.

Hiram T. Langston, M.D.

AMERICANS VIEW THEIR MENTAL HEALTH. Gerald Gurin, Joseph Veroff, and Sheila Feld. $7.50. Pp. 444. New York, Basic Books, Inc., 1960.

This volume is an important contribution to the status of mental health in the United States having been prepared by the Survey Research Center for the Joint Commission on Mental Illness and Health. The directors of both organizations, Dr. Angus Campbell and Dr. Jack R. Ewalt, supported and encouraged the total study.

The survey on mental health in the nation was launched to measure the level at which people were living with themselves and to investigate their anxieties, weakness, strengths, and how problems are met and coped with under varying circumstances. Some 2,500 adults over twenty-one years of age selected by methods of probability sampling were interviewed by the Survey Research Center, and two broad areas were covered by the data collected in the interviews: (1) feelings of adjustment and (2) methods of handling emotional problems. In the first large group is considered a galaxy of subjects, and these are chapters listed as: General Adjustment, Perceptions of the Self, Marriage, Parenthood, Job, Symptom Patterns, and Selected Demographic Characteristics and Adjustment. In the second large area is included: The Readiness for Self Referral, People Who Have Gone for Help, A Critical Group, Personal and Informal Resources, and Availability of Resources.

From these two large spheres necessarily come summaries, conclusions, and implications as to how Americans are facing their emotional problems. The average person recognizes subjective psychologic difficulties which he will not accept with apathy but instead with the awareness that he requires; then he will seek help. This high degree of self perception and willingness for Americans to admit that they have problems and weaknesses is prevalent throughout the country and gaining stronger utterance than heretofore. Unfortunately there is a shortage of trained mental health personnel to aid in this education program.

This excellent study has raised social and economic questions as well as questions on mental health which cannot be avoided or brushed aside. The problem is all around us and is a continuing professional and public responsibility. More studies such as this one help emphasize the pressing problems in the field of mental health today. Everyone in the discipline should read the facts as outlined in this splendid tome.

Louis D. Boshes, M.D.

Enthusiasm is the best protection in any situation. Wholeheartedness is contagious. Give yourself, if you wish to get others. —*David Seabury*

God does not want us to do extraordinary things: He wants us to do ordinary things extraordinarily well. —*Bishop Gore*



After a history and a physical ruled out organic disease, the physician diagnosed the case as recurring states of anxiety. To relieve these symptoms for this busy, on-the-go housewife, he prescribes Meprospan-400, the *only* meprobamate in *sustained-release* form.



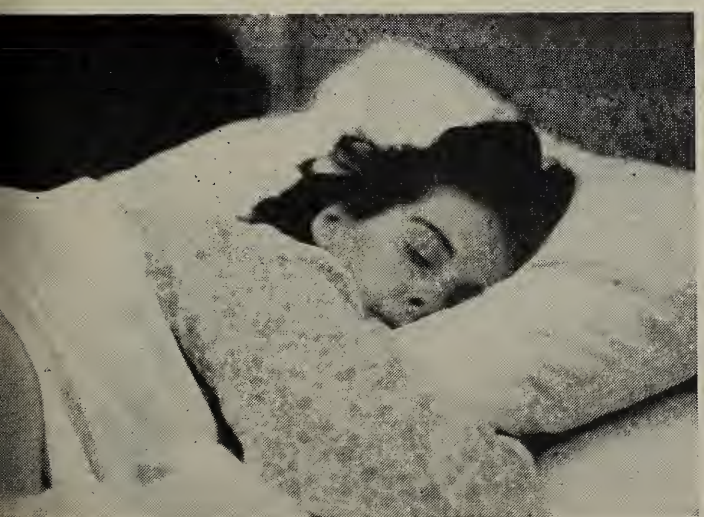
As directed, the patient takes one Meprospan-400 capsule at breakfast. Her symptoms of tension and nervousness are soon relieved, and she will not have to remember to take another capsule until dinnertime.



Calm and relaxed, the patient is no longer upset by the pressures and irritations met in everyday life, nor is she likely to be incapacitated by autonomic disturbances, drowsiness, ataxia or other untoward reactions.



Alert and attentive, the patient participates in a P.T.A. meeting, following her second capsule of Meprospan-400 taken with the evening meal. Meprospan-400 does not decrease her mental efficiency or interfere with her normal activities or behavior.



Peacefully asleep, the patient enjoys beneficial rest . . . Meprospan-400 has relieved the tensions that previously prevented sleep or kept her tossing and turning throughout the night.

most widely prescribed tranquilizer . . .
most convenient dosage form . . .

ONE CAPSULE LASTS 12 HOURS

Meprospan®-400

400 mg. MILTOWN® SUSTAINED-RELEASE CAPSULES

Usual dosage: One capsule at breakfast lasts all day, one capsule with evening meal lasts all night. **Supplied:** Meprospan-400, each blue-topped *sustained-release* capsule contains 400 mg. Miltown. **Also available:** Meprospan-200, each yellow-topped *sustained-release* capsule contains 200 mg. Miltown. **For children:** Capsules can be opened and the coated granules mixed with soft foods or liquids.

Both potencies in bottles of 30.

Samples and literature available on request.

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CME-3356

Sunlight and aging skin

During a lifetime, the skin is exposed to a large amount of irradiation from sunlight. This, of course, varies with occupation, recreational habits, geographic factors, and clothing. Unna was first to call attention to the high incidence of skin cancer among sailors exposed to sunlight, and his findings and conclusions have been confirmed by others. Although carcinogenesis has been emphasized adequately, there has been relatively little comment in the literature in regard to the role sunlight plays in aging of the skin. Many visible signs of aging are the results of accumulated ultraviolet damage. Such findings are evident both grossly and histologically. Among the changes related to exposure to sunlight are a dry, coarse, and leathery appearance of the skin; laxity with wrinkling; and various pigmentary changes. With its natural protection, the Negro skin has much less actinic damage, and elderly Negroes often manifest a deceptively youthful appearance. *John M. Knox, M.D. Harmful Effects of Sunlight. Texas J. Med. Aug., 1960.*

The price of haste

Some years ago a white explorer was conducting a safari in darkest Africa, and for four days he had driven his native bearers unmercifully. They covered perhaps twice as much mileage as usual on such a trip. But on the fifth day he got up all ready to go early in the morning, and the natives were all squatting on their haunches, and they refused to move. Well, he berated them and urged them to no avail. And finally the leader spoke up and he said, "My men say that for the last four days they have traveled so rapidly and so far that they have left their souls behind. They are just going to sit here and wait until their souls catch up to their bodies. *W. D. Snively, Jr., M.D. Medical Practice a Century Ago. Arizona Med. Aug., 1960.*

Action and feeling go together and by regulating the action which is under the more direct control of the will, we can regulate the feeling, which is not.

—*William James*

Reliable

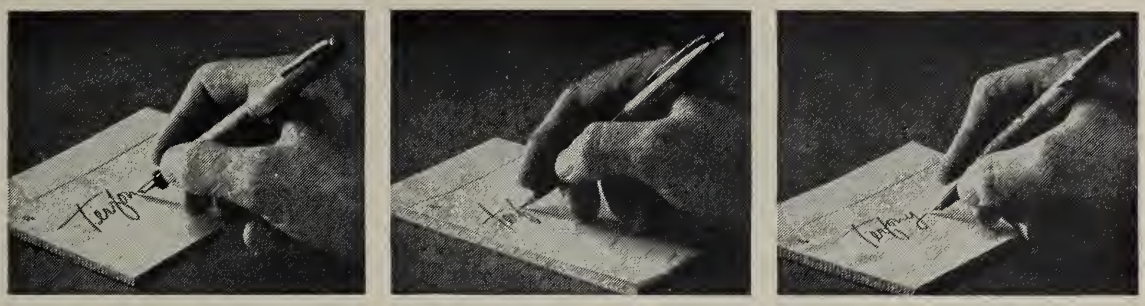
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We need particularly to develop at the University of Chicago a comprehensive and outstanding group working in the field of molecular biology. This field concerns itself with the ways in which individual molecules, such as nucleic acid molecules, act within a cell so as to direct the activities of the cell or to participate in its actions and reactions. Fortification of the workers in this area will, in my view, provide a more bountiful local spring for the nourishment of our own efforts in Chicago in behalf of the cancer problem. We must also nourish the channels of communication and of development, wherein fundamental knowledge is refined and adapted locally . . . for application to human disease. We must assure ourselves that patients with malignant disease will always find at the University the most modern hospitals, the most learned physicians, and the most up-to-date facilities and equipment, so that in the decades ahead all our patients will have the full benefit of modern knowledge without a day's unnecessary delay. *H. Stanley Bettett, M.D. Address to Board of Trustees of the University of Chicago Cancer Research Foundation. Dec. 1, 1960.*



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Sarcoidosis

To put before you briefly a picture of this disease is very difficult because it is so varied in its manifestations. It may present itself with manifestations in the skin. I mention this first, because that is historically the way it first came to medical attention. The most frequent way in which it presents itself, these days, is through its pulmonary manifestations, largely because of the widespread use of routine chest radiography. In the early stages, and sometimes throughout the whole course, the rather striking pulmonary manifestations may cause no symptoms at all, and for this reason they are frequently found on routine radiography of apparently well people. Sarcoidosis may come to light as the result of an appearance of a generalized enlargement of lymph nodes, and in such cases it can mimic such conditions as Hodgkin's disease and other forms of reticuloendotheliosis. Quite frequently it comes to light because of manifestations in the eyes, such a chronic iridocyclitis, usually bilateral but sometimes unilateral. Occasionally, the patients first have general constitutional symptoms. *J. D. Scadding, M.D. Sarcoidosis. Delaware M. J. June 1960.*

Dr. Kendall's research

I must add too that over the continuing years in which Doctor Edward C. Kendall carried on his adrenal studies many were skeptical of much of importance coming out of them, and since it was a very expensive laboratory to maintain, from time to time objections were raised to its continuation. Fortunately Mr. Harry J. Harwick and members of our sciences committee and of the Board of Governors backed Doctor Kendall from year to year until he attained success, but I shudder to think that had it not been for a few men, particularly those whom I mentioned, Kendall's work would have been discontinued because of the expensive character of the research. *Waltman Walters, M.D. A Surgeon's Progress. Minnesota Med. June 1960.*

The employer generally gets the employees he deserves.

—*Sir Walter Bilbey*



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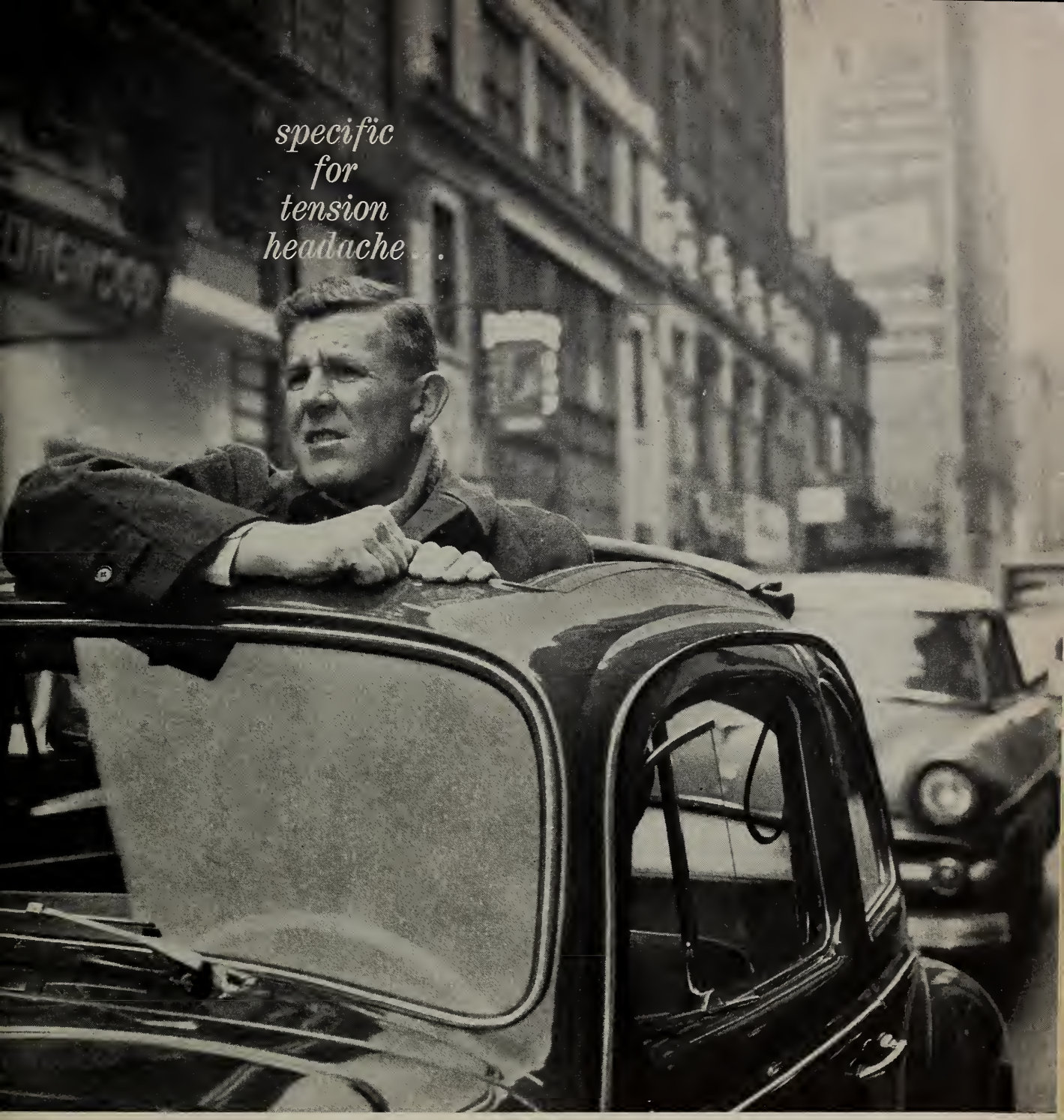
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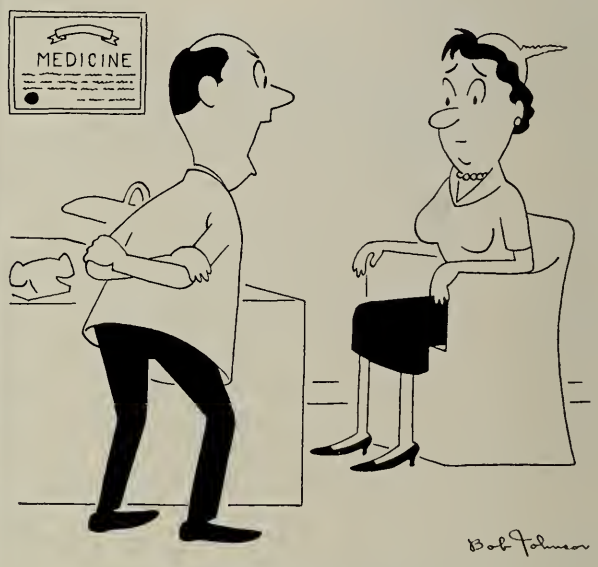
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He who is plenteously provided for from within needs but little from without.

—*Goethe*



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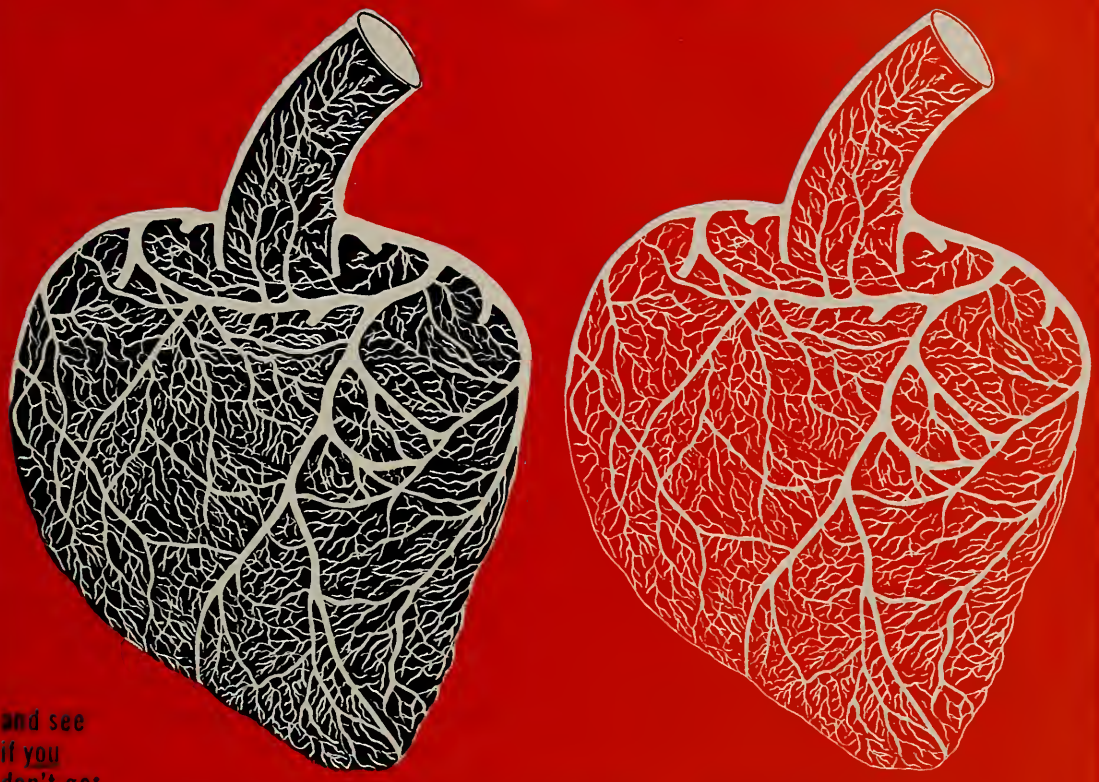
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Unanswerable question

Now I can't avoid answering a question addressed to me: 'Why do some people die suddenly of heart attacks after the doctor has given them a clean bill of health?' I have a standard reply to this. I say, 'If I knew the answer to this, I would be working for the life insurance companies only!' *Howard B. Sprague, M.D., as recorded in the Congressional Record, March 5, 1959.*

A barking dog is often more useful than a sleeping lion.

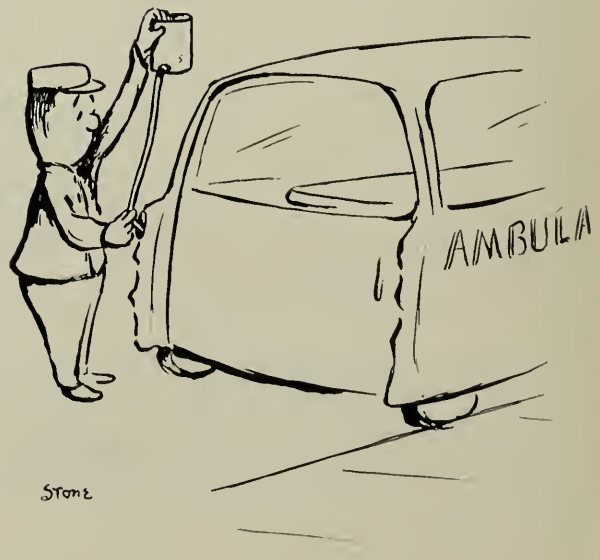
—*Washington Irving*

Manifestations of sarcoidosis

Discussion of the relative frequency of the early manifestations of sarcoidosis is not very rewarding because the incidence in any series will depend very largely upon the interests of the physician who reports it. Naturally, if a dermatologist talks about sarcoidosis, all his cases have skin lesions; and all the cases going to an ophthalmologist are likely to have eye lesions. Among my cases, a large majority, naturally, have lung lesions. And it is very difficult indeed to get a true idea of the relative incidence of early symptoms of sarcoidosis. But even allowing for this bias, I think that it is the intrathoracic manifestations which most frequently lead to the discovery of the disease. However, I will start, because it is historically correct to do so, by pointing out some of the skin lesions that may occur in these cases. *J. D. Scadding, M.D. Sarcoidosis. Delaware M. J. June 1960.*

The place of research

We can no longer rationalize our failures by looking hopefully and complacently at the nation's medical schools which are primarily devoted to teaching medical students what is known and what is not known and only secondarily to research. Research, indeed, must become a primary aim and basic purpose of the professional program in our hospitals. Peter W. Bowman, M.D. *The Role of the Psychiatrist in the Care and Treatment of the Mentally Retarded. J. Maine M. A. June 1960.*



Abstract of Council Actions

Meeting of January 29, 1961



KERR-MILLS IMPLEMENTATION AMENDMENTS APPROVED IN PRINCIPLE

Suggested amendments to the Public Assistance Code to create an Illinois program of medical assistance through implementation of the Kerr-Mills Act was approved in priciple by the Council.

State enabling legislation is required in order to take advantage of the federal matching funds available under the bill to help the near needy aged meet medical care costs. The amendments, recommended by a Special Ad Hoc Committee, Chairman, Dr. E. W. Cannady, set forth the conditions. The approach would take care of catastrophic or continuing diseases or conditions. The IPAC would be the administrative agency.

AMENDMENTS TO MEDICAL PRACTICE ACT SUGGESTED

The Council went on record favoring certain amendments to the Medical Practice Act which will be prepared and submitted to the State Legislature.

MEDICAL CARE PROGRAM FOR OVER 65 GETS A-1 PRIORITY

The Finance Committee of the Illinois State Medical Society gave A-1 priority to a program for implementation of the Kerr-Mills Law in Illinois and the extension of private insurance as a means of meeting the medical care problems of those over 65. The program also will include resistance to the passage of federal legislation of the Forand type.

It was explained by Dr. Edward A. Piszczek, chairman of the Council, that the headquarters staff may be required to defer some of the other projects which have been proposed by committees, in order to carry out the over 65 program.

PHYSICIAN-LAWYER CODE OF CO-OPERATION CONSIDERED

A proposed Professional Code for Physicians and Lawyers was discussed but action was deferred in order to permit Council members to become familiar with all phases of the code. The feeling was that if the Council should approve the draft in principle, the matter should be presented to the House of Delegates for its approval.

Dr. Newton DuPuy, chairman of the Liaison Committee to the Illinois Bar Association, reported that the two professions are coming closer together.

DISTRICT MEETINGS CONTINUED

District meetings in Chicago February 8, for the Third District, and in Decatur, February 12, for the Seventh District, will be completed by the date of this publication. Other meetings are scheduled for the Ninth District in Harrisburg on March 30, and the Fifth District in Springfield for April 6. This completes the coverage of all districts in the state for the year 1960-61.

SPRINGFIELD OFFICE SITE CHOSEN

Arrangements have been completed for rental of the second floor of a building at 520 South Sixth Street, Springfield, for use as the Springfield office. Possession will be taken about March 1.

STATE SOCIETY TO BE HOST TO ILLINOIS LEGISLATORS

Members of the Illinois Legislature will be guests of the Illinois State Medical Society at a dinner in Springfield, April 18. This is a biennial event, held during the sessions of the Legislature. The speaker will be Col. George M. Knauf, medical director at Cape Canaveral, Fla.

APPROVE RECOMMENDATION FOR MENTAL HEALTH DEPARTMENT

The Committee on Mental Health submitted a recommendation, concurred in by the Council, that the ISMS endorse Gov. Kerner's program for the establishment of a Department of Mental Health to care for the mentally ill and mentally retarded children in Illinois.

CO-SPONSOR NAMED FOR ORATION IN MEDICINE

Council approved a request from the Illinois Chapter, American Society of Internal Medicine, to co-sponsor the Oration in Medicine at the 1961 annual meeting.

SYMPOSIUM ON MANAGEMENT OF STROKES APPROVED

Upon the recommendation of the Committee on Aging, Council approved a symposium on modern concepts of the management of strokes, to be presented at the annual meeting.

The committee also reported that it is contemplating a state-wide program to encourage the use of modern rehabilitative techniques in the care of stroke patients. This will likely take the form of demonstration projects for physicians, nurses, nursing home attendants, and others concerned with the care of victims.

EMERITUS AND RETIRED MEMBERS ELECTED

Council approved emeritus status for Drs. E. A. Bredlau, Arthur I. Edison, Ellis B. Freilich, Gerard N. Krost, Louis A. Loewenberg, Harold A. Rosenbaum, Simon H. Soboroff, Eugene Talbor, and John P. Woitalewicz, all Chicago Medical Society, and Carl S. Williamson, Vermilion County.

The following were elected retired members: Drs. Joseph E. Barss, Lawrence F. Draper, Leo L. Hardt, Walter H. Hawkins, Paul C. Hodges, Cora A. Matthews, John T. McCormick, Thomas C. McDougal, C. Phillip Miller, John F. Ruzic, H. Prather Saunders, Marion Cole-Schroeder, and Henry A. Smith, all Chicago Medical Society, and Joseph T. Maher, Vermilion County.

CHANGE IN APRIL COUNCIL MEETING DATE

The meeting of the Council scheduled for April 16 has been changed to a luncheon meeting, April 18, and will be held in Springfield because of the dinner for legislators on that date.

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Vol. 119, No. 2 **February, 1961**

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Published monthly by the Illinois State Medical Society, 360 N. Michigan Avenue, Chicago 1, Ill. Subscription $4.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, Hawaiian Islands, and Mexico. $6.00 per year for all foreign countries included in the postal union. Canada, $4.50. Single current copies 50 cents. By mail, 60 cents.

Entered as Second Class Matter Nov. 12, 1952, at the Post Office, Mendota, Illinois, under the Act of March 8, 1879. Acceptance for mailing at special rate of postage provided for in section 1102, Act of Oct. 8, 1917, authorized July 15, 1918.

POSTMASTER: Send notices on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago 1, Ill.

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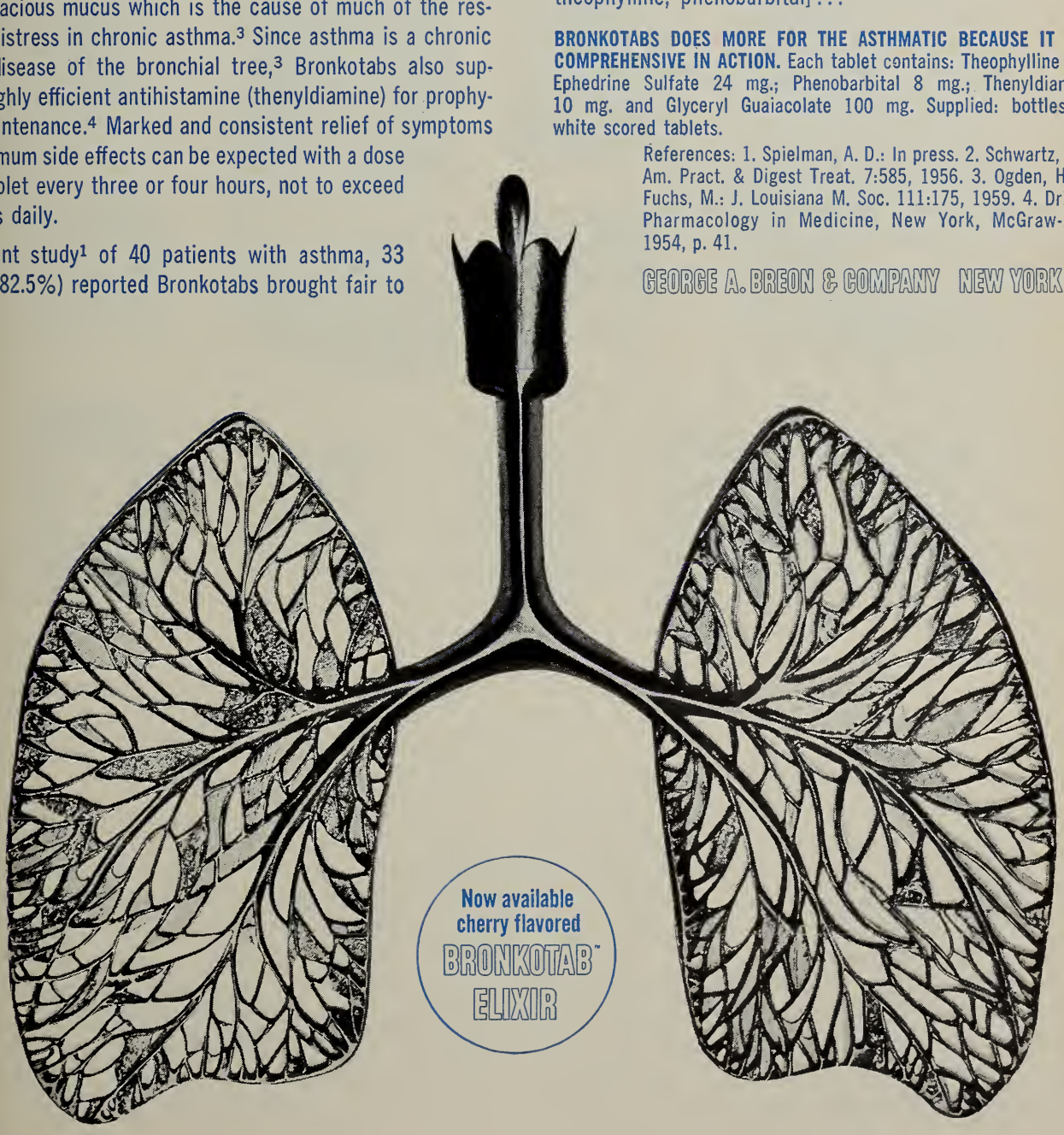
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References: 1. Spielman, A. D.: In press. 2. Schwartz, E., et a Am. Pract. & Digest Treat. 7:585, 1956. 3. Ogden, H. D., a Fuchs, M.: J. Louisiana M. Soc. 111:175, 1959. 4. Drill, W. Pharmacology in Medicine, New York, McGraw-Hill C 1954, p. 41.

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The Month in Washington



Spokesmen for the medical profession at the White House Conference on Aging supported the Kerr-Mills voluntary program for health care of elderly persons as an efficient, economical way to furnish assistance to those who need help.

Leading physician delegates to the conference also continued vigorous opposition to the social security approach espoused by organized labor.

Continuing their all-out campaign for the social security approach, labor union leaders used the conference as a forum for further attacks on the medical profession.

Dr. J. Lafe Ludwig of Los Angeles, chairman of the American Medical Association Council on Medical Service, told a pre-conference meeting of the physician delegates that it would be a "national tragedy—unfair to old and young alike—if the Kerr-Mills law should be shelved for a social security plan for medical care of the aged.

"Federal medicine would mean red tape, bureaucratic control, and high costs," Dr. Ludwig said. "Most important of all, it would mean inferior medical care for the people whom we are trying to help."

Describing the Kerr-Mills law as a "historic milestone, "Dr. Ludwig said the "overwhelming majority" of the nation's physicians believe it is "an excellent law which can and will work and deserves every opportunity to do so."

Dr. Leonard W. Larson of Bismarck, N.D., president-elect of the AMA, told the conference's Health and Medical Care Section that more attention must be given to keeping older persons healthy. He was chairman of the section. "We spend millions of dollars and hours developing sound, well-based programs for care of the sick, but at the same time we virtually ignore the vast opportunities for preservation and promotion of health," Dr. Larson said.

"We must do more than react to the minority of older persons who are ill—we must act for the great majority who are well."

In a satement issued in Chicago, Dr. E. Vincent Askey of Los Angeles, president of AMA, branded as false an allegation that the White House Conference had been "captured" by organized medicine, private insurance and business interests. Dr. Askey specifically referred to such a charge made by Prof. Wilbur J. Cohen of the University of Michigan, but the AMA president's statement applied to similar charges made by representatives of organized labor.

Dr. Askey implied that, "if anyone has a legitimate complaint regarding the choice of personnel directing the activities" of the key section on income maintenance, it was opponents of the social security approach.

Dr. Ludwig also answered organized labor's attacks on the AMA at the conference. Dr. Ludwig accused George Meany, president of the AFL-CIO, of "attempting to undermine" the conference to "further his own partisan interests.

(*Continued on page 22*)

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WASHINGTON (Continued)

Meany obviously is prepared to go to any extreme to impugn the motives of those who disagree with him," Dr. Ludwig said. "Delegates to this conference representing medicine and many other groups came here in a spirit of cooperation determined to take realistic action to help the elder citizens of this country. Meany, through his campaign of smear and hostility, is making this difficult, if not impossible."

Dr. Ludwig said that some labor leaders "obviously are more interested in saddling the people of this country with a system of socialized medicine" than he is in "helping those older people who really need help. Meany and such of his cohorts as Sen. Pat McNamara (D., Mich.) appear to be doing their utmost to create so much confusion that recommendations of the State Conference on Aging will be forgotten. Of the 30 states making specific recommendations regarding financing of medical care for the aged, only 10 favored the social security tax."

President Eisenhower urged the 2,700 delegates to the conference to reconcile their differing views and agree on a sound program. He told the delegates it was their responsibility to provide "some kind of guidance for Congress to use in its future deliberations."

President John F. Kennedy declined an invitation to address the conference as President-elect. He and Congressional Democratic leaders decided weeks before the conference to make medical care for the aged under social security an administration priority bill for early submission to Congress.

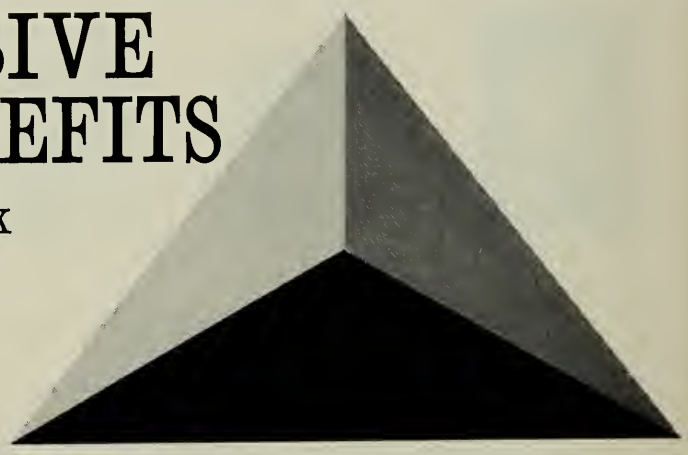
But some key Democrats in Congress announced they would not go along with President Kennedy on the issue. Sen. Robert S. Kerr (D., Okla.), co-author of the medical-care-the-aged program approved by Congress last year, said it should be financed by a general tax—"not a limited tax like social security."

Similar opposition to the social security approach was expressed by Sen. John J. Sparkman (D., Ala.). Chairman Harry F. Byrd (D., Va.) of the Senate Finance Committee earlier had said he was convinced that providing medical care for the aged under social security would

(*Continued on page 25*)

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lead to socialized medicine and possibly bankrupt the Social Security trust fund.

Despite the Kennedy Administration's espousal of the social security plan, the AMA pledged its continued cooperation to the Department of Health, Education and Welfare on other health programs.

A group of AMA officials headed by Dr. Askey told the news HEW secretary, former Gov. Abraham Ribicoff of Connecticut, at a pre-inaugural conference that the association "pledges its continued cooperation to HEW to work for the best medical care for the nation." The AMA "has always had a deep sense of responsibility for the health needs of the people," Dr. Askey said.

The AMA officals also advised Ribicoff that they would help implement the Kerr-Mills law in any way possible.

Testing for organic brain disease

The most important rule in the diagnosis of organic brain disease is to suspect its presence in all patients over 50 years who have psychiatric disease. In the mental status examination, indispensable tools are the Serial Sevens examination (subtracting sevens from one hundred, a problem which the average high school graduate should solve in two or three minutes with no more than one or two errors); recitation of digits forwards and backwards; and a test in which the patient is asked to remember three objects, the names of which were given him at the beginning of the interview. Calling for the interviewer's name or other details, such as his previous meal, and testing his ability to handle proverbs are helpful indices. These, of course, are only screening tests, and more subtle information may be derived from several specialized examinations. One which has proven useful and easy to administer is the Benton Visual Retention Examination (The Psychological Corporation, 304 East 45th Street, New York 17, New York). *Irvin D. Yalom, M.D. Organic Brain Diseases of Senility. Maryland Med. J. December 1960.*

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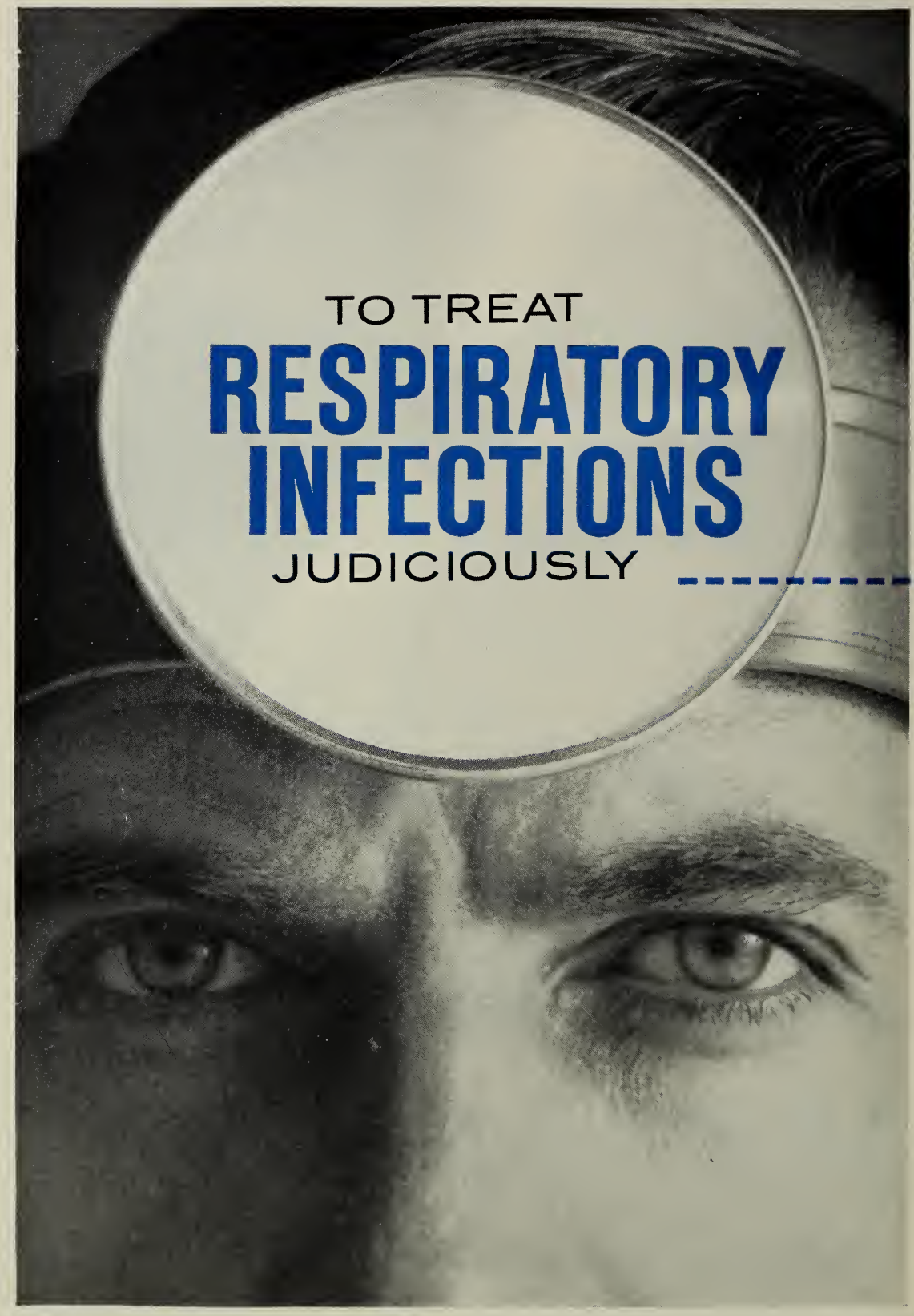


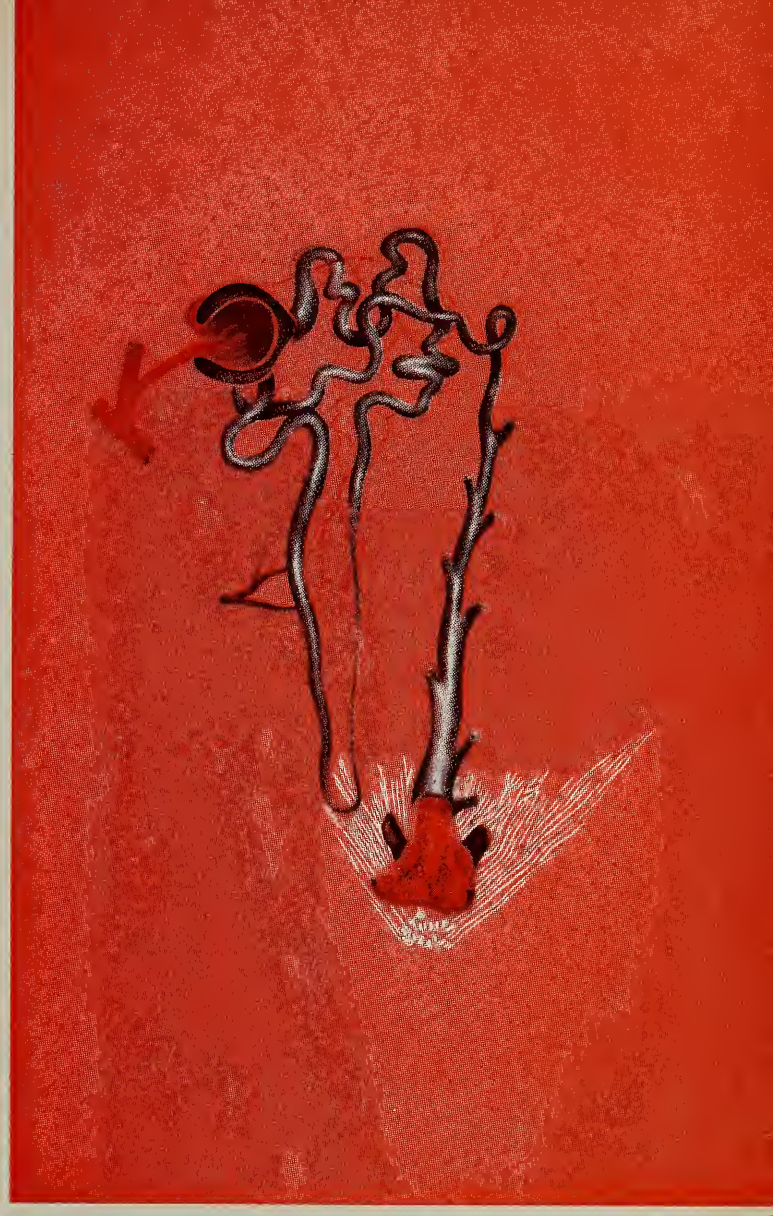
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References: 1. Schreiner, G. E.: A.M.A. Arch. Int. M. **102**:32, 1958. 2. Freedman, L. R., and Beeson, P. B.: Yale J. Biol. & Med. **30**:406, 1958. 3. Rocha, H., et al.: Yale J. Biol. & Med. **30**:341, 1958.

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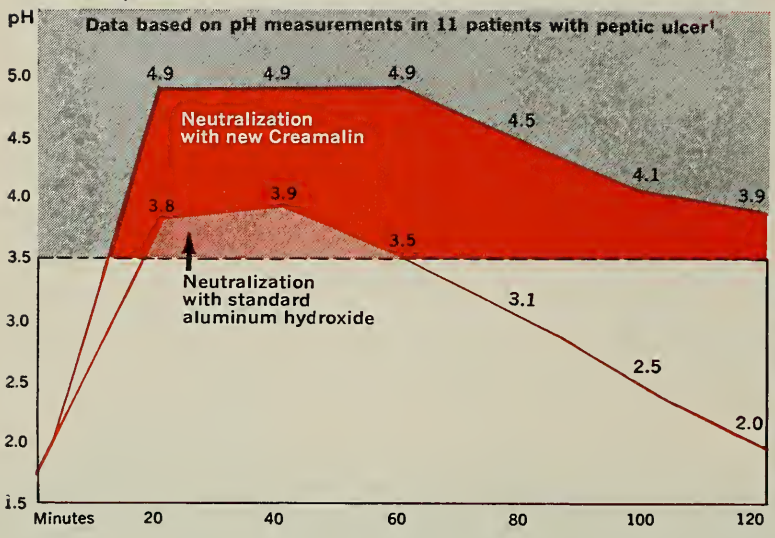
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The ILLINOIS Medical Journal

Official Journal of The Illinois State Medical Society

FEBRUARY, 1961
VOL. 119, No. 2

Asthmatic Bronchitis Versus Bronchial Asthma

ROBERT J. BECKER, M.D., *Joliet*

THE PURPOSE of this paper is to discuss the semantics of "asthmatic bronchitis versus bronchial asthma" and to attempt to establish criteria to aid in the differential diagnosis.

To the clinical allergist seeing pediatric patients, the term "asthmatic bronchitis" is almost as frustrating as the expression "—but we were told that he'd grow out of it." The frustration results from (1) lack of unanimity of definition of the term, and (2) the connotation that the disease is innocuous, self-limited, and unrelated to other factors in the patient's history and background. Frequently the diagnosis is made as a hedging maneuver and is reminiscent of pathologic microscopic diagnoses which are "compatible with but not diagnostic of." If the symptom of asthma is added to the diagnosis of bronchitis, why are other symptoms not added to this diagnosis? For example, why are there not diagnoses of acute febrile bronchitis, acute tussic bronchitis with the subdivisions acute productive tussal bronchitis or acute nonproductive tussic bronchitis? The obvious reasons are that these labels are cumbersome, verbose, and unrevealing of the underlying pathology. The basic problem in instances in which the diagnosis of asthmatic bronchitis is made is the inability to determine whether the episode is due to a respiratory infection in an asthmatic child during an attack of asthma, or whether it represents wheezing in a nonatopic child with infectious bronchitis.[1]

At the time of the episode of "asthmatic bronchitis," this differentiation may be difficult because the clinical pictures may be similar; however, careful scrutiny will reveal significant differences.

There is no question that episodes of acute tracheobronchial or bronchiolar infections may occur, resulting in the presence of the physical sign of expiratory wheezing along with other physical signs. Under these circumstances the diagnosis of acute infectious bronchitis (with wheezing, if you will) can be made without question or argument. To call this "acute asthmatic bronchitis" makes no more sense than to call it "acute febrile productive tussic bronchitis."

For the purpose of this discussion, the fact remains that the diagnosis of acute infectious bronchitis can be made in two groups of youngsters: those atopic youngsters with bronchial

Presented before the Allergy Section, Illinois State Medical Society, Annual Meeting, May 26, 1960.

asthma, and the nonatopic, nonasthmatic children. If this occurs in the nonatopic, nonasthmatic child, why needlessly label him with diagnosis of asthmatic bronchitis?

The atopic, asthmatic children present different problems. The paroxysms of asthma may be precipitated by respiratory infection or may be noninfectious and instead be induced by exposure to allergenic environmental substances. These children may present several problems: (1) The episodes of "asthmatic bronchitis" may occur frequently, to the distress of parents and patient. (2) Of almost equal distress, episodes of "frequent colds" may occur. Because of these apparent "colds" and episodes of asthmatic bronchitis, these children may receive frequent and large amounts of antibiotics, gamma-globulin, and "cold shots;" they may also undergo unnecessary tonsillectomies and adenoidectomies.

In reality these episodes of "asthmatic bronchitis" may represent one phase in the natural history of an allergic child. The allergic child may likewise experience allergic dermatoses such as eczema and urticaria, allergic rhinitis, occurring either perennially or seasonally, and typical pollen bronchial asthma. "Frequent colds" may actually be an extrinsic allergic rhinitis.

That an asthmatic child may experience an acute paroxysm of bronchial asthma with an episode of respiratory tract infection is well-accepted clinically. Why asthma may be precipitated in these instances resolves itself into two premises: (1) that the asthma occurs as a result of bacterial hypersensitivity,[2] and (2) that the respiratory infection irritates the bronchi, disturbs the allergic equilibrium, and acts as a nonspecific stimulus in the production of attacks of asthma.[3] I have no desire to enlarge upon this controversial subject, only the desire to repeat that bronchial asthma precipitated by respiratory infection is a well-accepted clinical fact.

There are certain other well-accepted clinical facts and observations concerning youngsters with bronchial asthma:

1. There may be a family history of allergic manifestations (other than drug reactions).
2. The patient may have a history of acute urticaria or flexural eczema.
3. The patient may have a history of seasonal or perennial nasal symptoms such as rhinorrhea (with serous secretions), sneezing, or "allergic salute."
4. The patient may have asthma during the warm months without respiratory infection.
5. Obvious allergic symptoms (nasal, bronchial, or dermal) may occur upon contact with animals.
6. Paroxysms of bronchial asthma may be present without temperature elevation.
7. Smears of the nasal secretions will frequently show a predominance of eosinophiles — and there may be a blood eosinophilia.

In addition, the asthmatic child may experience episodes of acute respiratory infections with asthma more frequently than the nonasthmatic child.

Diagnostic criteria

Although the human organism is a dynamic, unpredictable, and variable entity, medical practitioners frequently need and appreciate categorical diagnostic criteria. It is therefore suggested that criteria be established to aid in the differential diagnosis of bronchial asthma as opposed to asthmatic bronchitis. It is further suggested that these criteria be divided into major and minor criteria, as in Jones' classification of rheumatic fever.[4] The major criteria are:

1. Family history of hay fever, asthma, acute urticaria (not due to drugs), or allergic dermatitis (flexural eczema type—not due to contact).
2. History in the patient of acute urticaria (not due to drugs) or an allergic dermatitis.
3. History in patient of nasal symptoms (rhinorrhea, sneezing, or "allergic salute") during warm or cold months.
4. History of allergic symptoms upon contact with animals of any kind.
5. History of asthma during warm months without respiratory infection.

The minor criteria are:

1. Occurrences of paroxysms of asthma without significant temperature elevation.
2. Asthma always preceded by rhinorrhea (serous secretions) for a variable period before attack.
3. Therapeutic response of wheezing to epinephrine.
4. Presence of predominance of eosinophiles in nasal secretions or peripheral blood eosinophilia.
5. Repeated epsisodes of asthma with infection (arbitrarily three or more during one winter).

It should be noted that no mention is made of a history of drug reaction, because there is some question as to whether hypersensitivity to drugs is more prevalent in the allergic individual than in the nonallergic. There also is no mention of positive skin tests, because it is felt that the diagnosis should be made primarily on a clinical basis.

The presence of one major or two minor criteria in a patient having bronchial asthma with respiratory infection is adequate evidence for a diagnosis of bronchial asthma rather than asthmatic bronchitis. Thereafter, it behooves the practitioner treating the patient to manage him as an allergic individual with bronchial asthma. This implies an evaluation of the environment for allergenic inhalants, clinical evaluation for possible food sensitivities, and the like.

Summary

The differential diagnosis of asthmatic bronchitis and bronchial asthma has been discussed. It is suggested that the term asthmatic bronchitis be discarded. It is also suggested that in the nonatopic, nonasthmatic child, the diagnosis of acute bronchitis be made; in the atopic, asthmatic individual, the diagnosis of acute bronchial asthma be made. Diagnostic criteria have been suggested to aid in differentiating between the two clinical entities.

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Anginal pain inhibitors

The Mono-amine oxidase (MAO) inhibitors diminish both the intensity and frequency of anginal pain and increase the capacity for exertion; they have been used widely during the past several years, therefore, in the treatment of this condition. We have used iproniazid, isocarboxazid, pivalylbenzhydrazine and, with Dr. Willard J. Zinn, beta-phenylisopropylhydrazine. Our results agree in general with most of those published in the literature. Our patients felt better with medication than they felt before—were more alert, more cheerful and had greater tolerance for activity. Many of them were able to remain gainfully employed or to return to jobs they previously had had to quit.

There is some question as to whether these agents merely afford symptomatic relief, or whether they actually cause an increase in efficiency of the heart muscle. We have already discussed several factors which may be operative.

It is difficult to determine whether the analgesic activity of these compounds is most important, or whether the anti-anginal effect may be due specifically to the rise in pain threshold, to central nervous system stimulation, or to psychic effects. The exact role of coronary dilation or oxygen-sparing effects also is uncertain. When these agents were first used, it was believed that the entire anti-anginal effect was owing to the anti-depressant factor, but the development of inhibitors which depressed or had no effect on drive and activity indicates that the psychic element may not be as important as had been thought. *Robert W. Oblath, M.D. and George C. Griffith, M.D. The Aminase Oxidase Inhibitors. California Med. December 1960.*

Clinical-Surgical Conferences



Cook County Hospital

Traumatic Injuries To the Major Abdominal Vessels

Moderator:
Robert J. Freeark, M.D.
Director, Department of Surgical Education
Cook County Hospital

Discussant:
Thomas Starzl, M.D.
Department of Surgery, Northwestern University Medical School

Dr. Robert J. Freeark: For those of you visiting this Conference for the first time, it might be of interest to know that this is a weekly occurrence at County. Our practice has been to take some of the interesting material encountered here and invite speakers, both from outside the hospital as well as from our own staff, to discuss the various problems encountered in the surgical wards of this hospital. Finding a speaker to discuss traumatic injuries to the major abdominal vessels is not an easy task. Most prominent vascular surgeons are somewhat removed from the emergency traumatic vascular injury as encountered in a large charity hospital. In a hospital such as ours, the therapy of major vessel injury usually falls to the resident or house staff, simply because this type of injury is most frequently the result of gunshot or stab wounds, only occasionally nonpenetrating trauma and, as such, are seen first by the house officers. Therefore, as a rule, the younger generation of surgeons deals with these problems.

With us today is, by his appearance, one of these younger surgeons. In terms of experience, however, he has aged rapidly as the result of some of these traumatic vascular problems. Dr. Thomas Starzl is a member of the faculty at Northwestern University Medical School. His travels since our undergraduate days together have included places like Johns Hopkins University and Hospital, the University of Miami, and the Jackson Memorial Hospital. He is certified in both general and thoracic surgery, and throughout his training has been interested in vascular surgery. He had an unusual experience several years ago in encountering a number of these major vascular injuries while a resident and staff officer at the University of Miami. He has written an excellent article on traumatic injury of the vena cava, and he is well qualified to discuss the two cases we will present today.

Case 1

Dr. Edward Beheler, surgical resident: A 22 year old Negro male was admitted to Cook County Hospital on March 20, 1960, at 8 a.m. four hours after sustaining a single gunshot wound in the right upper portion of the abdomen. His blood pressure was 80/40mm. Hg, pulse rate 108 per minute, respiration 30 per minute. The significant physical findings were limited to the abdomen, which was rigid, tender, and silent. No exit wound was noted. Urinary catheterization returned 370 cc. of clear urine,

and stool benzidine was 3 plus. Admission hematocrit was 33 per cent.

One and a half hours after admission, with blood running via an arm "cutdown," the patient was taken to the operating room. Under general endotracheal anesthesia he underwent a laparotomy through a right paramedian incision. The abdominal cavity was filled with blood which arose chiefly from a through-and-through wound of the right lobe of the liver. There was a large retroperitoneal hematoma which, on mobilization of the right colon and duodenum, had resulted from a tangential wound of the anteromedial wall of the inferior vena cava and, in addition, complete transection of the splenic vein at its union with the superior mesenteric vein. The latter wound caused partial loss of the medial wall of the portal vein. In addition, there was a through-and-through wound of the second portion of the duodenum just distal to the bulb, and a transection of a major lymphatic channel.

Dr. Freeark: You can appreciate the blood bath that Dr. Beheler found himself in. I have drawn on the blackboard the anatomical problem that was presented to the surgeon. All structures are retroduodenal and retropancreatic. The splenic vein was sheared off with some injury to the portal vein. The vena cava behind these structures was tangentially injured.

We will ask the patient to come in now (patient entered). His recovery has been remarkably uneventful. He has some residual drainage from the drain site but is really doing quite well (patient left). Dr. Starzl, the discussion is now all yours.

Dr. Thomas Starzl: I would compliment Dr. Beheler on this remarkable achievement of salvaging such a patient. It is a very unusual circumstance to have recovery from inferior vena cava injury. In 1956 there had been only seven reported instances of recovery after gunshot wound of the inferior vena cava, and six of these occurred in nonmilitary injuries. The only military wound recovery occurred in the British army. The American army had no reported survivals in these cases in World Wars I and II and the Korean War. This may have been due to serious injury both to the vena cava and other viscera, which precludes survival if there

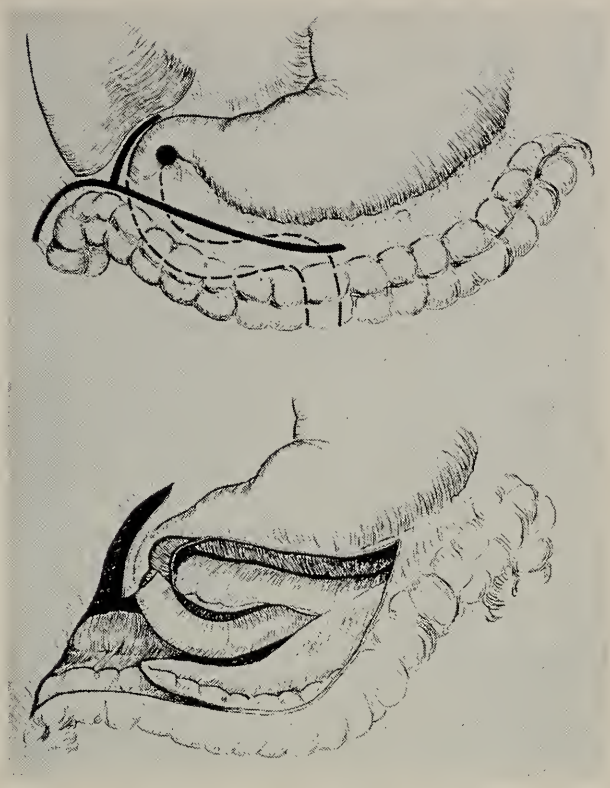


Figure 1. (After Russell Drake) Peritoneal incisions (above) and reflections (lower) for exploration of the inferior vena cava above the level of the renal veins. The location of the bullet tract in Case 1 is indicated by a solid circle (The American Surgeon 23:455, 1957).

is a prolonged period between the time of injury and operation. The time lag may account for the fact that most survivals have been in civilian injuries, which can be treated promptly.

In the fall of 1956 we had the opportunity within a period of 10 weeks to see and treat three cases of inferior vena cava injury. One of these was above the renal veins and is the second reported case of survival after injury in that location. Dr. Beheler's is the third case, since there have been no reports since ours in 1957. During the care of these patients and in reviewing the literature, certain principles of therapy became apparent. I would like now to try to develop them and draw some comparisons to the case presented.

The first case we saw in a 27 year old Negro male, shot in the abdomen at close range. The wound of entry was almost exactly between the umbilicus and the xiphoid process and passed trans-abdominally, the wound of exit being in the right costovertebral angle. The patient was in

shock. A "cutdown" was placed, and he was taken immediately to surgery where he was given 2,000 cc. of blood and was explored. We found a trajectory very similar to Dr. Beheler's, except that the wound of entry into the retroperitoneal space was located higher (Fig. 1). It injured the duodenum in two places and nipped off the margin of the pancreas and then disappeared.

The first thing that seems to be common to all these injuries was noted by Dr. Beheler too; it is that, although there was a good deal of blood in the peritoneal cavity, truly massive hemorrhage had ceased by the time the patient was explored. If this were not the case, I don't believe any of them could be treated. Instead of having continuing exsanguinating hemorrhage, the signal finding in this case was the presence of hematoma behind the pancreas. We suspected injury of the common duct and portal vein, and we did several things because of this. We enlarged the incision, obtained good light, made sure we had plenty of blood available, placed IV's in the arm, and added vascular instruments on the table. We then explored the area of the hematoma, incising the superior leaf of the transverse mesocolon and brushing the mesocolon down, thereby mobilizing the hepatic flexure (Fig. 1). By a Kocher maneuver, we got into the area of the hematoma and had massive bleeding, controlled by a desperate finger thrust into the bleeding hole in the vena cava. We eventually managed to get control above and below the site of injury.

This brings up the second thing to mention: In vena caval injury, if you have a number of intercostals emptying into the vessels between the controlling clamps above and below, the collateral drainage from the lumbar vessels may be so profuse as to allow hemorrhage almost as severe as if the major vessel were open. This is different from the arterial injury, and eventually you will have to apply local pressure or a curved clamp and isolate that segment.

Our first patient had injury to the common duct, duodenum, and pancreas and some small bowel perforations; but he survived. He actually had a fairly uncomplicated course.

The second case occurred a short time later. In this instance the wound of entry was at just about the same place. It entered the retroperitoneal space at the ligament of Treitz; so it was below the renal vein (Fig. 2). There was injury of the contiguous aorta, and when the patient was explored, a hematoma was found in the retroperitoneal space. Massive bleeding had ceased, and there was plenty of time to make the necessary arrangements, including enlarging the incision, securing good lighting, having the blood checked, a "cutdown," and so on. In this instance the hematoma was pulsating slightly, and we suspected aortic injury. Just as we completed arrangements to explore the retroperitoneal space, the false aneurysm ruptured, but it was not hard to control. The aortic lesion and the vena caval lesion were repaired.

I think this type of injury is the basic cause for one of the most common late complications of inferior vena cava injury, that is, development of aortic-inferior vena cava fistula. This case provided a perfect set-up for such a fistula, some of which have been discovered 10 days to 10 years after the primary injury.

The third case I will mention to condemn our management. Again the injury was just at the ligament of Treitz (Fig. 2). In this instance the patient had been shot as he was fleeing from

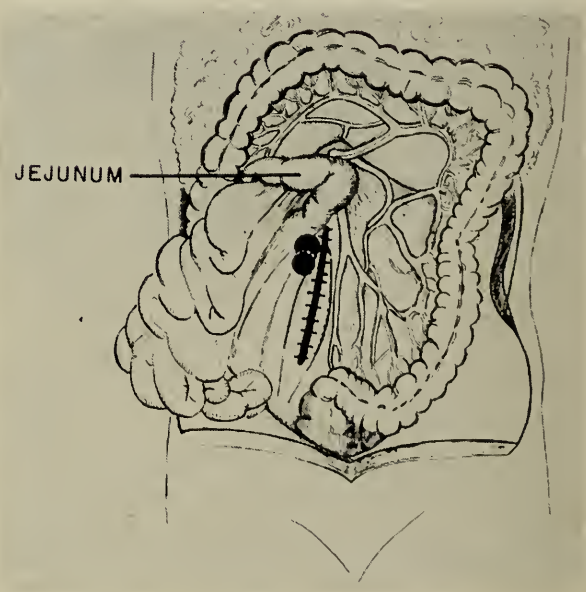


Figure 2. (After Kay Hyde) Peritoneal incision through the left leaf of the small bowel mesentery at its base for exposure of the inferior vena cava below the transverse mesocolon. The upper and lower solid circles indicate the levels of caval injury in Cases 2 and 3 respectively of the discussion (The American Surgeon 23:461, 1957).

the scene of a crime. The bullet, entering the back, had lost some of its velocity by the time it hit the vena cava. There were two linear tears in the vessel. The bullet also ripped off some of the lumbar veins, but the patient was not in shock and did not look particularly ill. We did not suspect major vessel injury; but on entering the abdomen, we found the telltale hematoma and cessation of bleeding. An assistant was intrigued by the hole in the retroperitoneal space. He put his finger into it, and when he took it out, there was massive hemorrhage of 1,000 cc. of blood. A finger was put back into the hole immediately and stayed there for two or three hours. In this injury the basic exposure of the vena cava was provided by an incision at the base of the mesentery of the small bowel, but the injury was so extensive that we could not get good exposure. Therefore, the entire small bowel was removed from its attachment to the retroperitoneal space and with most of the colon was brought up on the chest so that the retroperitoneal space was widely opened. In addition to the two vena caval tears anterior and posterior and the areas where the lumbars had been ripped off, this man also had multiple small bowel perforations. We tried to control bleeding by controlling the iliacs, but we tore the iliac vessel.

This again illustrates the problem of control of massive venous bleeding. It was impossible in this case to do that with clamps at any distance above and below the site of injury, making local pressure necessary. This patient recovered but developed iliofemoral thrombosis. He was finally discharged from the hospital a month later.

I would like now to answer a question which I am sure many of you must be asking yourselves: If you have a wound in the inferior vena cava with a small retroperitoneal hematoma and bleeding has ceased, why is it necessary to explore the space to repair the vessel? You do this because you have no assurance that bleeding will not recur. In Dr. Beheler's case as in our cases, there was injury to other retroperitoneal structures which could not have been satisfactorily repaired without getting into the area of the hematoma. Such untreated retroperitoneal injuries have a mortality of 100 per cent; that is the reason why repair is necessary in most of these cases.

What were the lessons we learned from our own cases? In those patients who actually get to the hospital with such injuries that can be treated, massive bleeding has ceased. On exploration of the abdomen the signal finding is a retroperitoneal hematoma usually, but not always, large. When it is found in the vicinity of the great vessels, a methodical program for exploring the retroperitoneal space should be instituted before manipulation is done, including getting blood, adjusting the lighting, preparation of necessary vascular instruments, and planning a wide exposure, which usually involves extending the original incision. For vena caval injury below the transverse mesocolon, exposure can be obtained by making an incision along the base of the small bowel mesentery. For injury above the transverse mesocolon, the best exposure is a combination of the Kocher maneuver with mobilization of the colon and sweeping down the transverse mesocolon. The ultimate in exposure in lesions below the transverse mesocolon can be obtained by detaching the entire small bowel from the retroperitoneal connections and putting it on the chest wall.

Despite the fact that these are venous injuries, we did not use anticoagulants in our cases, and we do not think they are indicated unless the lesions are unusually severe and multiple.

The final lesson from our cases is worth remembering: Two of the patients were shot by irate husbands who caught them in their wives' bedrooms!

Dr. Freeark: A word to the wise is sufficient. Now I would like to reemphasize several of Dr. Starzl's points. Having vascular clamps ready at surgery is very important. Dr. Beheler has said that they were available to him on the initial exploration without having to wait to have them sterilized. This he thinks was a significant factor in the patient's recovery. Vascular clamps adequate to deal with these problems should be part of every emergency laparotomy set-up.

The performance of venous "cutdowns" in the arm is equally important. Many patients are taken to the operating room with the "cutdown" in a leg. We had the experience of pumping about 10 pints of blood into the leg of a patient with injury in the iliac vein, and the majority of the blood was coming right out the wound up above. It was only late in the course of events that this

was recognized. An arm "cutdown," therefore, is a very important factor.

What about ligating the portal vein? Would you feel that that is inevitably fatal?

Dr. Starzl: In the dog, ligation of the portal vein is fatal, but man usually tolerates it. Dr. Childs conducted an experiment with dogs and monkeys and found there was little fatality in monkeys. This is presumably due to the fact that in the monkey retroperitoneal venous collaterals are better developed because the area around the pancreas and duodenum is plastered to the retroperitoneal space, whereas it is not in the dog. He has done portal vein ligation in man as the first stage of a Whipple operation, and he has not had a fatality. By the time the patient is ready for the second stage, the portal pressure has generally returned to normal.

Dr. Freeark: Were those veins partially occluded?

Dr. Starzl: That is always a possibility in case of tumor, but in monkeys it was not a consideration. I think it would have to be accepted that there is an additional factor of tributary clotting in the type of portal occlusion that gives portal hypertension. It is not simply main vessel obstruction.

That brings up the problem of trying to ligate the vena cava at the level that Dr. Beheler's patient's injury occurred. It is generally accepted that that would almost always be fatal. Dr. Beheler could not have done anything else here, since most investigators feel that death ensues if acute ligation is done above the renal vessels.

Dr. Freeark: The genitourinary service has ligated above the renal vessels in patients whose tumors have occluded the vein. I am sure that there must be a long series of unreported vena caval injuries that have occurred during the performance of lumbar sympathectomy, and anyone who has been in on such a problem has learned about getting proximal and distal control. It is very effective to take two stick sponges and apply point pressure at a right angle to stop blood loss from a tangential injury of the lateral vena caval wall.

It is curious how these cases will come to us in threes. Between the two cases presented today, Dr. Norcross had a patient with a through-and-through gunshot wound of the vena cava above the renals, and he had some difficulty in dealing with the posterior wound. That patient did not survive. Did you learn any special lessons from that case?

Dr. William Norcross, department of surgery: Our case demonstrated the difficulty in adequately exposing the vena cava high in its abdominal course and the malevolent effect of massive transfusion on the normal clotting mechanism. It further demonstrated the difficulty in obtaining proximal control of the vena cava in this area. The entrance wound was apparent in the right 5th intercostal space in the nipple line. On exploration of the abdomen, there was evidence of previous intraperitoneal hemorrhage. No active bleeding was encountered at this time. On further exploration, it was seen that the bullet had entered the abdominal cavity and traversed the liver to enter the vena cava anteriorly just inferior to the hepatocaval juncture. The hematoma anterior to the vena cava was deceptively small, no larger than 5 cc. There was moderate to marked pericaval fibrosis, apparently subsequent to previous intraabdominal inflammatory disease. It was apparent that proximal control could be obtained only by extending the right paramedian incision into the chest, incising the diaphragm and mobilizing the right lobe of the liver. Unfortunately, while this was being accomplished, there was onset of massive hemorrhage from the caval wounds. The bullet, entering anteriorly, had traversed the cava obliquely and exited posteriorly at the level of the adrenal veins. Though bleeding could be controlled with digital pressure, it was soon apparent, even with mobilization of the liver, that the space of required dissection was so small that it was difficult to dissect and at the same time be able satisfactorily to control oozing from the posterior vena caval wound. This circumstance resulted in an unfortunately large loss of blood, requiring massive replacement. Once adequate exposure was obtained, the wounds were repaired with little further difficulty. On closure and throughout the postoperative period, we were confronted with a rather constant ooze from all wounded surfaces. A hematologic consultation was obtained, and a diagnosis of thrombasthenia was made. This was treated with ACTH, frozen plasma, and so on, but the patient continued to bleed and expired on the third postoperative day from the consequences of this acute blood dyscrasia.

QUESTION: In the case presented by Dr. Beheler how was the portal or splenic vein handled?

DR. FREEARK: The splenic was ligated and the portal was repaired. Ligation of the splenic vein is usually well tolerated. It was not felt that it was necessary to remove the spleen.

What about the splenic artery? If you had to sacrifice it would you think the spleen should come out?

DR. STARZL: No. We have done elective surgery with the use of the splenic artery. We did a splenorenal arterial anastomosis. In lesions of the upper abdominal aorta, such as renal artery stenosis, we have cut the splenic artery and mobilized it and revascularized one of the kidneys, but we did not think of removing the spleen.

QUESTION: I would like to know the approach to repair in this case.

DR. FREEARK: They took down the hepatic flexure of the colon and mobilized the duodenum, much as outlined by Dr. Starzl. I believe it would prove satisfactory for most injuries above the transverse colon.

QUESTION: What would you do in a through-and-through wound of the vena cava?

DR. STARZL: I would repair both anterior and posterior rents. A technic which is intriguing but one we did not use would be to close the posterior hole from within the vessel. This would involve leaving one silk knot within the lumen, but it would avoid the difficulty of exposing the posterior wall of the cava from its external surface.

Case 2

DR. DALE SNYDER, surgical resident: A 38 year old Negro male entered Cook County Hospital on Oct. 28, 1959, an undetermined time after sustaining a gunshot wound of the chest.

On admission he appeared terminal and was described as stuporous, cold, and clammy. His blood pressure was 70/40 mm. Hg, pulse rate 72 per minute, respiratory rate 20 per minute. An entrance wound was over the left seventh rib just medial to the anterior axillary line. No exit wound was noted and the chest was clear to physical examination. The abdomen was soft, not tender, but bowel sounds were absent.

A unit of plasma was started, followed by saline while blood was being prepared. Emergency roentgenograms revealed a clear chest and a metallic object in the projection of the retroperitoneal area below the diaphragm. Urinalysis was negative and emergency hematocrit was 36 per cent. Exploration two hours after admission revealed wounds of the transverse colon, proximal jejunum, and right renal artery at the junction of the aorta. The left renal vein in the portion crossing anterior to the aorta was partially severed.

DR. FREEARK: This patient's problem is also shown on the blackboard. He too presented the problem of a surgical approach to a great deal of active bleeding that was not retroperitoneal but intraabdominal. His left renal vein was partially severed, as was the right renal artery at its origin from the aorta. Bleeding could be controlled by a well-placed sponge and pressure. The problem was how to get proximal control. In order to get at the wound in the aorta, it was necessary to complete the transection of the renal vein. This finished, the patient had a pulse in the renal artery, but there was some narrowing that presented the question of ischemia to the right kidney. The situation was equally disturbing on the left because the left vein was sacrificed, and I assume that ligation of a renal vein is just as fatal as ligation of the vena cava above the renal vein. Here we had the problem of renal venous death on the one side and renal artery death on the other side. What should we have done here?

DR. STARZL: I expect the patient was dying at the time he was explored so your hands were forced, and you did what you could do quickly to avoid having him die on the table. You knew at the time that ligation of the renal vein is almost inevitably followed by death of that kidney. Except for certain anatomical anomalies, death will follow in all cases. The type of anomaly that might lead to salvage of the kidney is periaortic venous plexus in which part of the venous return of the kidney goes behind the aorta and part in front so you have a periaortic ring. In such a case you could ligate the anterior branch without harmful effect since the posterior branch would take care of it. But that only occurs in 2 to 10 per cent of cases. In this particular case I would have been tempted to cut off the right renal artery and reanastomose it to the aorta, because in a young patient with supple vessels

this procedure would not be too difficult. These aortic injuries are better understood and treatment is more standardized than the venous injuries. Essentially it consists of control above and below the site of exit; the repair of vessels is not difficult because the collateral inflow is not great.

Dr. Freeark has opened the door for a discussion of the complicated vascular lesions at the level of the renal artery in which obtaining control involves temporarily devascularizing certain viscera, such as the kidney, which in itself may have a terrific mortality. I am sure, in this case, that to do any more than they did would have meant greater insult to the kidney. It takes at least 15 minutes to accomplish a reanastomosis of one of these visceral arteries, and as a result, the patient may have ischemia of the organ that surely leads to death.

Dr. Freeark: Dr. Starzl is the author of a brilliant movie. He and his group undertook a thromboendarterectomy of the aorta in which the thrombus involved not only the renal artery but the superior mesenteric. He handled the vascular supply to these organs by a series of partial occlusion clamps.

Dr. Starzl: That patient had had for years a thrombus that extended from the terminal aorta distally. Six months before he came to us he had malignant hypertension; he had symptoms of intestinal angina with abdominal pain after eating; and he had a blood pressure that was often 300. The thrombus had completely occluded the left renal artery. The right renal artery was reduced to a stenotic area, and there was partial occlusion of the superior mesenteric artery. This man was cooled and we explored him. The incision used could be applied to high aortic injuries. A vertical abdominal incision is extended into the ninth intercostal space. You lift the pancreas and spleen to the right, and do the usual left colectomy mobilization. We made that incision, put clamps on above the superior mesenteric artery, and removed the thrombus. The period of occlusion on this was about one hour. The patient's temperature was 30 C., and we had postoperative evidence of pretty severe bowel injury with hemorrhage. He survived, but he was awfully sick.

Dr. Freeark: We felt that our patient had two sources of venous outflow from the left kidney. He had a large adrenal vein above it and a good sized spermatic vein distal to the point of ligation. We hoped that the adrenal venous outflow could come down through the spermatic and pick up return to the heart that way. On the arterial side there did not seem to be anything more in order. This patient was anuric postoperatively. His blood pressure was restored for a while, but he expired two days after surgery.

Dr. Snyder: Postmortem examination revealed a right kidney that appeared normal light brown in color. The pathologist said it was only very slightly congested with some contraction of the right renal artery. The left kidney was large and pale; it looked like a "shock kidney." The large dilated spermatic and adrenal veins on that side showed there was some utilization of that collateral channel, but it was not adequate. There was a typical "shock kidney" picture on the left.

Dr. Freeark: Have you had experience with venous grafts in humans in replacing segments of vein?

Dr. Starzl: I have not personally, and those who have worked with them have reported poor results. Veins have no pressure to keep them open. They look good at first but slowly shrink down and occlude. Dr. DeBakey has said categorically that venous grafts will fail particularly below the diaphragm; he thinks they should not be used.

Dr. Freeark: How do you feel about draining such a repair?

Dr. Starzl: We drained all our cases extensively. I think the tip of the drain should be close to the suture line, and we use Penrose drains.

Dr. Freeark: We all thank you, Dr. Starzl, for an interesting and helpful discussion.

Points to be remembered

1. Major vascular injury represents one of the few true surgical emergencies of abdominal trauma.
2. While gunshot and stab wounds account for most such emergencies, it is important to remember that they may occur in non penetrating trauma. Vessels, such as the inferior vena cava, may be lacerated by blunt trauma.
3. In most instances the need for surgical intervention is obvious, and the major preoperative efforts should be directed toward restoration of blood loss and the assessment of damage to

viscera not readily examined at the time of laparotomy.

4. The following sins of omission are to be avoided in the preoperative evaluation of such a patient:
   (a) Failure to identify the path of a missile in which there is no exit wound. General condition permitting, failure to establish course of the missile by anterior-posterior and lateral x-rays based upon the missile's resting site. Some apparently penetrating wounds may be quickly reclassified as nonpenetrating.
5. The degree of preoperative restoration of blood volume is one of the most difficult decisions to make, and there is no good laboratory aid to assist. Most patients with major vascular wounds who arrive at the hospital alive will be benefited by preoperative transfusions and some delay in operative intervention.
6. Where a major vessel wound to the vena cava or iliac vessels is anticipated, it is wise to place the "cutdown" in an arm vein rather than a leg, so that transfused blood is not immediately lost through the wound in the vessel.
7. The operative management of major vessel injury requires a knowledge of what vessel may safely be ligated, and which ones must be repaired or the viscera they supply be resected.

In general the following vessels must be repaired:

(a) Aorta and iliac arteries
(b) Hepatic artery propria (distal to right gastric and gastroduodenal artery)
(c) Superior mesenteric artery and vein
(d) Inferior vena cava above the renal veins
(e) Portal vein

The following vessels should either be repaired or the viscera which they supply removed:

(a) Cystic artery (gallbladder)
(b) Appendiceal artery (appendix)
(c) Renal artery and vein (kidney)

Second CAMP MEMORIAL LECTURE

John B. Reckless, M.B., Ch.B.

Duke University Medical Center, Durham, N.C.

"The Facts of Life in the Future of Medicine"

May 17, 1:30 P.M.

Grand Ballroom Sherman Hotel

Reversibility of Atherosclerosis

C. Bruce Taylor, M.D., George E. Cox, M.D., and Richard E. Trueheart, M.D., *Evanston*

The rather general acceptance of the concept that atherosclerosis is not reversible warrants comment. All too frequently one hears such remarks as: "He is fifty years old and his arteries have been accumulating atheromata for years. Since his arteries are already ruined and this is a 'one-way' process, there is no need to worry about his developing just a little more atherosclerosis." All evidence available is contrary to this defeatist concept that atherosclerosis is a "one-way" or irreversible process. Many years ago Krylow and Anitschkow, pioneers in the field of atherosclerosis, demonstrated its reversibility.[1,2] An excellent review of these early classical studies was published in English by Anitschkow in 1933.[3] The progressive resorption of lipids from experimentally induced atherosclerotic lesions is beautifully demonstrated in a series of illustrations in this report. Lesions, of course, regressed after serum cholesterol levels were brought back to normal. Reversibility of atherosclerosis has also been demonstrated in dogs[4a] and in chickens.[4b]

Those of us in pathology encounter a great deal of indirect evidence at the autopsy table indicating that atherosclerosis undergoes regressive changes. It is generally accepted that patients dying after relatively protracted periods of reduced dietary fat intake or with chronic wasting diseases have less atherosclerosis than patients of comparable age, race, and sex who have died suddenly. There is a modest amount of material in the literature comparing atherosclerosis in wasting diseases with the same affliction in patients dying suddenly.[5]

From the department of pathology, Evanston Hospital Association, and the department of pathology, Northwestern University School of Medicine.

While the Nutrition Committee of the Chicago Heart Association is sponsoring this article, the opinions expressed are those of the authors and do not necessarily represent the official view of that committee.

Although xanthomatosis of the skin and tendons is not considered atherosclerosis, it does represent abnormal accumulation of lipids comparable to those that accumulate in the intima of blood vessels. Indeed, the morphology, chemistry, and pathogenesis of these lesions are nearly identical with early atheromata. It is our belief that the rapid, visible regression of these lipid deposits, following reduction of serum cholesterol levels, provides the best direct clinical evidence we may ever have for the resorption of atherosclerotic-like lipid deposits.

Many of us have seen this phenomenon in patients; we have also observed it in diet-induced xanthomatosis in Rhesus monkeys. It is our experience that this regression occurs when serum cholesterol levels drop to about 500 mg. per 100 cc. of serum (precise limits in Rhesus monkeys cannot be set, but the range seems to be about 400 to 600 mg. per 100 cc.). Conversely, when serum cholesterol levels are increased, by diet, to levels over about 500 mg. per 100 cc., xanthomata enlarge and recur. It is of interest that the critical level for deposition of lipids in skin and tendons is about twice the critical level for deposition of lipids in arterial tissue (200-250 mg. per 100 cc.).

It is important to think of atherosclerosis as a "foreign body reaction" to an excessive accumulation of lipids in cells and interstitial spaces of arterial tissue. Further, under proper conditions, these irritating, destructive lipids can be removed from arterial tissue. Proper conditions are a reduction of the concentration of certain plasma lipids (with the total serum cholesterol level serving as an index of their concentration) so that the lipids can be mobilized and removed from the arterial wall.

This critical serum cholesterol level for arterial tissue has been experimentally shown to be 200-250 mg. per 100 cc.[6] Lipids accumulate in

arterial tissue when levels are above 250 mg. per 100 cc; they do not accumulate and probably are mobilized out of arterial tissue at levels below 200 mg. per 100 cc. Antischkow, in his original studies on reversibility of atherosclerosis, found that reversal of florid atherosclerosis in rabbits required 18 to 24 months. In his studies, after 18 to 24 months nearly all histologically demonstrable abnormal lipids had been mobilized leaving only a small, dense intimal scar.

The removal of the abnormally deposited lipids of atherosclerosis from the arterial wall is clinically important for several significant reasons: (1) The sheer bulk of these accumulated lipids actually reduces the lumina of smaller arteries. For example, atherosclerotic lesions in coronary arteries are composed mainly of lipids. These large deposits protrude into and markedly impinge upon the lumina of these arteries. If lipids are resorbed or mobilized out of atherosclerotic plaques, the caliber of coronary arteries will be increased towards normal. (2) The accumulated lipids in atherosclerotic lesions behave like foreign bodies and exert relentless and progressive irritative and destructive processes upon the arterial wall. In early lesions the irritative phase predominates and stimulates the formation of intimal scar tissue which narrows the lumina of arteries. Older lesions show marked medial destruction and intimal ulceration. The mobilization of lipids out of atherosclerotic lesions would inhibit further progress of these undesirable reactive processes. (3) The persistence of large amounts of lipids and the secondary scarring and destruction of the arterial wall that accompany them lead to considerable abnormal vascularization of arterial walls. Many new "vasa vasorum" course through degenerating atheromatous plaques. These thin-walled vascular structures often rupture and cause an obstructing hematoma within the wall of the artery. Such phenomena (intramural hemorrhages) frequently cause fatal coronary artery occlusion.

Summary

In our opinion, atherosclerosis should be regarded as a definitely reversible disease. Experimental and indirect clinical evidence indicates that lipids move into arterial tissue when serum cholesterol levels are above 250 mg. per 100 cc.; lipids are apparently resorbed from arterial tissue when serum cholesterol levels are below about 200 mg. per 100 cc. Cholesterol plaques should be thought of as resorbable "foreign" material just as one expects resorption of foreign materials from subcutaneous bruises, hematomas, traumatic subcutaneous fat necrosis or peanut oil as a vehicle for an injectable drug.

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Follow-up study on thrombosis

219 patients with femoro-popliteal thrombosis and 103 patients with aorto-iliac thrombosis were observed for an average period of three years after their first attendance at hospital. The results of treatment are analysed, showing that claudication in a large number of patients remained unchanged or improved on conservative treatment only. Angina and coronary thrombosis were common during the follow-up period, and the general mortality of this atherosclerotic group is high. The position of long-term anticoagulant therapy is discussed. *Adolf Singer, M.B. and Charles Rob, M.C. The Fate of the Claudicator. Brit. M. J. Aug. 27, 1960.*

Services for Aging and Rehabilitation

In Illinois Public Aid Commission

Elizabeth L. Breckinridge, *Chicago*

To prevent dependency in old age, to rehabilitate those already dependent, and to preserve a satisfying independence and well-being in old age insofar as possible, the Illinois Public Aid Commission appointed an Advisory Committee on Aging in January, 1954. Mr. William L. Rutherford, a Peoria lawyer, accepted the chairmanship. He was also secretary-treasurer of the Forest Park Foundation, which has been instrumental in developing a variety of health programs in Peoria, notably the Institute of Physical Medicine and Rehabilitation and the Peoria Home Care Program. This combination of interests later produced substantial benefits for old people in Illinois; but, initially, the Advisory Committee was concerned primarily with developing information and consultant services to help communities in Illinois start local programs to meet the needs of their older residents. These needs, of course, parallel those of all age groups — needs for work, recreation, housing, and constructive personal and community relationships as well as for physical and emotional health. On recommendation of the advisory committee, the commission established an information service and a community organization program. Shortly thereafter these were included in a Section on Services for Aging, which handles approximately 1,000 inquiries annually from the 102 counties in the state, as well as a growing number of requests from other states and other countries.

Even as these services were being developed, however, the Committee had its attention directed to one of the most difficult problems confronting the Illinois Public Aid Commission—what to do about the growing number of Old Age Assistance recipients requiring placement in nursing homes. This trend is shared with the rest of the United States as life expectancy increases, even though the total number of Old Age Assistance recipients is declining. Illinois State Mental Hospitals were also reporting an increasing number of older patients.

At that time, the committee noted a few statistics indicating the size of the problem: State expenditures for medical care for assistance recipients were about 75 per cent higher in mid-1953 than in mid-1951. Nursing home care for Old Age Assistance recipients accounted for approximately 50 per cent of these costs at the start of 1954 and hospitalization, of which three fourths was for Old Age Assistance recipients, accounted for another 25 per cent. In January, 1954, nursing home care cost $1,042,110, and hospitalization, $514,369.

Geriatrics Rehabilitation Program

It was at this point that the advisory committee received significant inspiration from the Institute of Physical Medicine and Rehabilitation in Peoria and from two men associated with it — Dr. Harold Vonachen and Dr. Worley Kendell. The committee was convinced that the only way to reduce the number of old people being admitted as public charges to nursing homes and state hospitals was to invoke the philosophy and skills of modern rehabilitation. It should be noted that in most parts of the country rehabilitation for the aged is still viewed with skepticism. The first step taken by the committee was to propose what became known as the Geriatrics Rehabilitation Program (GRP), which was approved by the Public Aid Commission on March 4, 1955.

This program was designed to operate in Cook County and in Peoria County, since both of these areas had the necessary facilities and personnel, so tragically lacking in most other areas

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Supervisor, Services for Aging, Illinois Public Aid Commission.

This is the seventh in a series of articles being sponsored by the Committee on Aging.

of the state. From OAA cases referred for placement in nursing homes and state hospitals, in Peoria a maximum of 10 persons per month could be admitted to the rehabilitation program; in Cook County, 15 persons.

The selection of persons admitted was carried out by a director of the program in each county in cooperation with local physicians. The actual screening process was a complicated one, differing somewhat in Peoria and Chicago. In Peoria, the director, Mr. Dale Larson, cleared possible admissions with the attending physician, the staff of the Institute, and a sub-committee of the County Medical Society. In Cook County, where Mrs. Rebecca Robinson directed the program, nursing home referrals channeled through a central Nursing Home Service of the Cook County Department of Public Aid, and a committee of key personnel in the cooperating hospitals served as the screening group.

In the Geriatrics Rehabilitation Program patients are given a diagnostic study (physical, psychological, and social) and then are provided with whatever treatment, tests, prostheses, or appliances are recommended by the attending physicians. In addition to the funds of the Public Aid Commission, grants from the Forest Park Foundation, the United States Public Health Service, and the State Department of Public Welfare were secured to pay for professional personnel.

Since OAA recipients being referred for nursing home care are quite old and suffering from an array of disabilities, hospital beds in conjunction with diagnostic and rehabilitative services are essential for the program's operation. In Peoria, the program was established in the St. Francis and Methodist hospitals and in the Institute of Physical Medicine and Rehabilitation. In Chicago, Michael Reese Hospital and Rest Haven became the cooperating agencies.

It is interesting that when the screening physicians were presented with the first case studies of candidates for the program, their enthusiasm was somewhat dampened by the age of the patients and the severity and complexity of their disorders. However, as one after another responded to intensive treatment, optimism was revived. This seems to be the experience of other groups engaged in geriatric rehabilitation in the United States. Given sufficient motivation and aided by supportive social service, the very old, very ill patient still possesses recuperative powers far beyond generally prevailing conceptions.

Points learned from program

Since the first patient was admitted to the program in January, 1956, what have we learned?

First, with discriminating screening, a very high proportion of patients could be returned to community living. About 70 per cent of patients admitted to the program in the two counties achieved this degree of recovery. Others were considerably improved but still required some kind of sheltered care. The average age of patients exceeded 75 years, the oldest being 90. He, incidentally, is, two years later, living alone and doing volunteer work!

Second, the geriatric rehabilitation patient is far from being an "old crock." As a clinical entity, he is a fascinating challenge to our professional skills, whether they belong to medicine, psychiatry, social service, or nursing. This has become obvious in the increasing involvement, dedication, and enthusiasm of all the professions working in this program.

Third, results came more quickly than anticipated. Originally we had estimated three months for intensive diagnostic study and treatment. The average period of hospitalization has been about 50 days.

Fourth, medical and social service follow-up of patients is essential to maintain the benefits of rehabilitation. The intensity of this varies from person to person depending not only on their physical condition but also on the presence or absence of other supporting factors in their lives.

Fifth, geriatric rehabilitation pays economic as well as human dividends. The average cost has ranged from $1,000 to $2,000 but the return to community living, as opposed to nursing home care, has resulted in average savings which pay for the cost of rehabilitation in a little more than a year's time.

By the end of 1958, after considering reports and recommendations from both counties, the Commission decided to liberalize the scope of both programs. The Peoria Geriatrics Rehabilitation Program was extended to two neighboring counties, and referrals on a case-by-case basis were authorized from other areas of the state. In both programs the categories of potential candidates were liberalized, some being taken

before referral for placement, some after placement, and some below the age of 65.

Since case finding and screening in the program necessarily took some time, many of the patients had already been placed in nursing homes before they could be visited. Physicians and social workers in these visits began to ask whether the concept of rehabilitation could not be carried into the 686 nursing homes in Illinois. At the same time, some of the more progressive nursing home administrators also were raising the same question. Was custodial nursing care the most the nursing home could offer? Must rehabilitation practically be confined to the highly specialized medical center? At this strategic moment, as if cued by Heaven, Miss Mary Switzer, Chief of the Federal Office of Vocational Rehabilitation, appeared on the scene in Peoria to make a speech and inspect the rehabilitation programs. Thanks to President Eisenhower's interest in rehabilitation, additional funds were then available for research and demonstration programs, and Miss Switzer indicated that consideration could now be given to some programs in nursing homes.

Rehabilitation Education Service

Thus encouraged, the Advisory Committee recommended, and the commission approved, the creation of the Rehabilitation Education Service (RES). The approval of this program, which was a complete innovation in the field of nursing education, was a remarkable testimonial to the commission's growing conviction that constructive health services were the only answer to one of its most vexing problems.

The educational service was designed to look for the answers to four questions:

1. What are the rehabilitation needs of nursing home patients?
2. How far may these needs be met by existing nursing home staffs?
3. What kind of a training program can be developed to provide nursing home staffs with the desirable knowledge of rehabilitation techniques and to increase their appreciation of the general philosophy of rehabilitation?
4. What kinds of teaching materials can be developed for use by other agencies and schools in order to increase the competence of nursing home staffs?

After the proposal was approved by the commission early in 1956, financing of staff salaries was secured for three years from the Federal Office of Vocational Rehabilitation. Medical supervision and training were obtained from the Institute of Physical Medicine and Rehabilitation through a grant from the Forest Park Foundation. As sponsor, the Illinois Public Aid Commission provided administrative supervision, office space, supplies, and other administrative financing.

In addition to the coordinator, Mr. John Hackley, professional staff was employed to form two teams. Each included two rehabilitation nurses and an occupational therapist. Fortunately, the project was able to attract personnel of the highest quality, combining enthusiasm, research and teaching ability, and excellent training and experience. After an orientation period, these teams were made available to go without charge into public or private nursing homes for a term of five to seven weeks. Each team provides an educational program including lectures, demonstrations, and return demonstrations in each home. The team is in the home four full days a week, reserving Monday for follow-up visits to homes previously served.

To be eligible for this service, homes must be licensed and must have a policy of admitting public assistance recipients. Prior to the entry of a team, a patient census is taken, and the nursing home administrator secures attending physicians' approval for patients to participate in the rehabilitation program.

The medical supervisor, Dr. Kendall, also reviews the patient group, visits the home, and provides consultation as needed to the Rehabilitation Education Service staff, the home staff, and attending physicians. In the training program every effort is made to include all nursing home personnel caring for the patients, including those on night shifts.

When the program is introduced, the home is asked to assign one person to be responsible for rehabilitation nursing and one to serve as activities director. The occupational therapist works intensively with the activities director to develop a planned and balanced program including crafts and social programs and mobilizing a wide range of activities with the aid of volunteers from the local community. The activities program has been a major factor in changing home environ-

ments and stimulating patients' motivation toward greater independence. As the total program is installed and the new concepts adopted, homes uniformly report decreases in the time required for nursing and increased patient participation in activities.

In the rehabilitation nursing phase, teams soon found that certain attitudes of staff and patients had to be overcome, notably the idea that everything should be done for the patient rather than engaging in the often more complicated process of teaching him to take care of himself.

The teaching materials and techniques have been carefully geared to the abilities and backgrounds of the average nursing home staffs. They embrace only those areas of care which presently can be used by nursing home personnel and adequately carried out within the framework of their program. For example, such physical therapy techniques as passive range of motion exercises and gait training may be carried out by supervised nursing personnel trained in rehabilitation.

Results of education program

More detailed reports on the operation and results of the service may be secured from the Section on Services for Aging of the Illinois Public Aid Commission, 160 North La Salle Street, Chicago 1. In summary, the Rehabilitation Education Service has been far more effective than we dared hope. Because of the obvious raising of the levels of service achieved, when the service terminated as a project at the end of 1959, the Illinois Public Aid Commission unanimously approved its continuation as a permanent service and extending its scope to homes for the aged and to small hospitals.

During the project period (1957-1959) 37 homes with more than 2,000 patients were served. These homes ranged in size from 17 to 236 beds. Although the service is not a treatment program but a staff training program, invariably questions are asked about the effect of the program on the patients. About five per cent of the patients indicated sufficient potential to warrant referral to the Illinois Division of Vocational Rehabilitation. Approximately 25 per cent responded to rehabilitative measures sufficiently to be discharged from the home. About 60 per cent of patients included in the program achieved an increased degree of self-care and independence in the nursing home. It is promising also that, increasingly, homes that have had this training are being used for maintenance rehabilitation or the completion of rehabilitation, thus shortening the patient's hospitalization.

So much interest has been aroused by the service, which has already inspired other programs in Michigan and Washington State, that teaching materials are being compiled for publication during 1961. Throughout the program the service has benefited from the wonderful cooperation of local physicians, nursing home administrators, and the Illinois Nursing Home Association, which provided invaluable interpretation of our goals and program.

In addition to the educational service, the commission also provides general program consultation to public and private nursing homes on request. This service was established in recognition of the fact that inappropriate structures, inefficient administration, and poor program planning result in inadequate services and directly increase the costs of care.

In 1959, State legislation (SB 999) was passed creating a State Advisory Council on the Improvement of the Social and Economic Status of Older People and placing on the Illinois Public Aid Commission responsibility for staffing the council. Mr. William Rutherford was appointed chairman by Governor Stratton, and three other members of the Commission's Advisory Committee on Aging were also appointed. At the time of writing, these are Sen. Paul Broyles, Mr. Raymond Hilliard, and Mr. Robert MacRae; among the other citizen appointments are Mrs. Florence Baltz, past chairman, Joint Council to Improve the Health Care of the Aged, and past president, American Nursing Home Association, and Dr. Edward Cannady, chairman of the Illinois State Medical Society's Committee on Aging. Ex officio members include Dr. Francis J. Gerty, state welfare director, Dr. Leroy Fatherree, state health director, and Mr. Peter W. Cahill, executive secretary of the Illinois Public Aid Commission, who also serves as secretary to the Advisory Council. It may be anticipated, therefore, that with the stimulus of this new Advisory Council the Public Aid Commission will continue its interest in developing ways and means to strengthen the health services for Illinois' older citizens.

The View Box

Franz Gampl, M.D., *Chicago*

This 62 year old white male was admitted to the hospital complaining of severe burning discomfort during urination. The onset of his illness was sudden in the early morning hours. His urine became bloody later on during the day, and the pain increased.

A similar episode occurred one year previously. It subsided under conservative management.

Physical examination revealed normal blood pressure, pulse, and temperature. The examination of the chest and the abdomen were noncontributory. The prostate gland was moderately enlarged and soft on rectal examination.

The urine was grossly bloody, positive for albumen and showed no reducing substances.

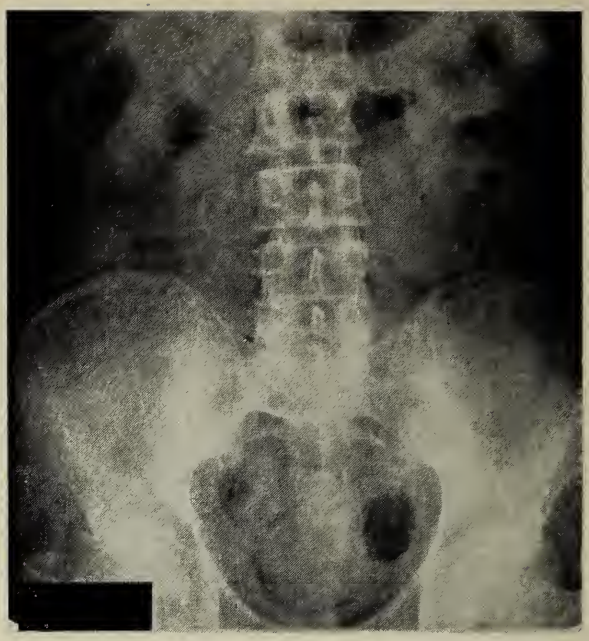


Figure 1. Recumbent film of the abdomen.

What is your diagnosis?

1. Bladder calculi
2. Bladder neoplasm
3. Cystitis
4. Normal recumbent film

(*continued on page 89*)

Carbon tetrachloride poisoning

Carbon tetrachloride is probably best known as an industrial poison. The dangers of inhalation are less well recognized than those of ingestion. A concentration of 1 part of carbon tetrachloride in 1,000 parts of air is said to be the upper limit of safety, and this may easily be exceeded if solutions containing carbon tetrachloride are in frequent use in a poorly ventilated room. Small doses may give rise to drowsiness, headache, nausea, and vomiting, and chronic poisoning may result in acute nephritis, toxic hepatitis, jaundice, and aplastic anaemia. Strans reported three fatal cases of aplastic anaemia occuring in patients whose work had involved the use of carbon tetrachloride as a cleaning fluid in premises with poor ventilation, and the writer has recently seen a cause of acute renal failure, fortunately not fatal, which followed the inhalation of fumes of carbon tetrachloride when a bottle containing cleaning fluid broke in a small ship's cabin. *Any Questions? Brit. M. J. Aug. 27, 1960.*

MEDICINE IN THE OUT-OF-DOORS



The Nation's Family Sport

JULIUS M. KOWALSKI, M.D., *Princeton*

FAMILY recreational pursuits are many and varied, some time-honored, and others ephemeral like Mah-Jong. But none can stand up to the rapid surge of boating. It is leaving all the others in its wake with crafts of innumerable sizes, shapes, colors, impervious materials powered by faster and more efficient motors. No other sport has had a comparable spectacular rise as boating enjoyed in the last decade, and it continues to increase.

The family get-togetherness which it allows is a hopeful sign at a time when many see the family unit crumbling. Boating is adaptable to the young at heart, the old and slow. It is refreshing and healthful for all. Millions are discovering our lakes and waterways—those areas formerly known only to the few hardy and bold. For the first time, many are gaining a slight appreciation of our vast natural resources in timber and water, and scenic beauty of the out-of-doors.

Compelling figures released by the Outboard Boating Club of America bear witness to this new family activity. Almost a fourth of the nation—more than 40 million persons—participated in recreational boating by making use of waterways more than twice in 1959. This segment of the population went afloat in more than 7 million crafts such as rowboats, canoes, dinghies and outboard boats which were powered by 6 million outboard motors. New models are added at more than half a million annually. Those who are not lake cottage owners or resorters but preferred to explore new waters at will, towed their crafts on 2 million trailers. No wonder that on many a summer weekend on a busy highway, unless a car had a boat trailer in tow, it appeared stark naked.

But what about the other side of this glittering coin? There is no pleasure but what there is pain. The Outboard Boating Club of America, ever mindful of its responsibilities to the public, spares no means to compile and evaluate all data relative to boating safety. This the industry has been doing for years prior to the establishment of state and federal agencies which now are just beginning to cope with this problem. The latest statistical release shows that boating is a safe recreation; but negligence, that culprit of most human dispair, must be resisted. Such actions as standing up in a boat, overloading, reckless operation, and sudden maneuvering — thoughtlessness at best — accounted for 54 per cent of fatal boating accidents in 1958. Unclarified official records, or lack of eye witnesses placed 22 per cent of the fatalities in the "unknown" category. Forces of nature, such as windstorms and other weather conditions, taken all too lightly so often by neophytes took a toll of 14 per cent. Mechanical and structural failure and miscellaneous faults were responsible for 9 per cent.

Surprising was the finding that boating fatalities for the nation remained nearly constant for an entire ten year period (1,243 in 1949 and 1,391 in 1958) while boating activity more than doubled during this interval. The fatalities per 1,000 motors in 1949 were 0.47 as compared to 0.25 in 1958. Data from the National Office of Vital Statistics disclosed that boating ranked ninth among causes of fatal accidents. A percentage breakdown per 100,000 population

showed: motor vehicle, 21.4; falls, 10.7; fire, 3.9; drownings, excluding boats, 2.9; railroads, 1.4; firearms, 1.4; aircraft, 0.9; poison, 0.8, and boat drownings, 0.7.

Boat operators involved in fatal accidents in the age group 20 to 39 had the highest rate, but the highest percentage of accident victims was in the 15 to 24 year old group. Males outnumbered females greatly among the victims, as well as operators involved.

Activities engaged in when accidents occurred, per-cent-wise, were as follows: general boating and cruising 47; fishing 43; water skiing 3.9; hunting 3.8; racing 0.1, and miscellaneous 2.4.

Despite the increasing interest in water skiing, the fatal accident cases dropped from 4.5 per cent in 1958 to 3.9 per cent in 1959. In all accidents, including water skiing, it was found that 40 per cent of swimmers were drowned, and among non-swimmers 65 per cent drowned. From the records it appears that too many swimmers over-estimated their abilities in reaching shore. "Stick with the ship or flotsam" is the axiom of mariners. The new boating laws enacted in all but several states last year required among other safeguards, a U.S. Coast Guard approved life packet or cushion for each person in a boat; it is a proper measure. And it is the solemn obligation of all to urge every non-swimming person to learn this healthful, pleasant, and in an emergency — life saving — activity.

Though the boughs still shake against the cold, the perennial harbinger of spring will soon be here. Nothing dispells the winter's gloom and heightens the spirits like a boat show. The best one in the nation will be held at the new Lake Front Exposition Center (McCormick Place) in Chicago from March 24 through April 2. This is where a family outing begins.

Old friends get together for the . . . .

Annual Meeting Dinner

Speaker: T. C. Petersen

American Farm Bureau

"This, too, is the practice of medicine"

May 17, 7 P. M. **Sherman Hotel**

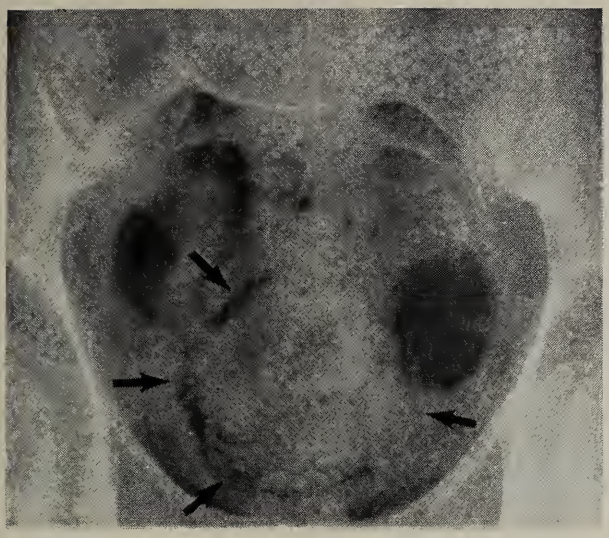


Figure 2. Cut-out from recumbent film.

The View Box

—diagnosis and discussion

(*continued from page* 86)

The diagnosis is cystitis emphysematosa.

The recumbent film showed the bladder shadow surrounded by a radiolucent halo of gas bubbles, a finding pathognomonic of this diagnosis (Fig. 2).

The intravenous pyelogram verifies the bladder outline surrounded by the gas in the bladder wall (Fig. 3).

Cystitis emphysematosa is an infrequently seen complication of cystitis. It is found in patients who have bladder infections produced by the coliform group of organisms. (The urine culture in this case showed Escherichia coli, Klebsiella, and Aerobacter organisms.) It is more frequently seen in diabetics. Although this patient never showed any positive urine sugar, his blood sugar values fluctuated between 108 and 182 mg. per 100 cc.

Cystitis emphysematosa is usually of transient nature lasting from 3 to 21 days. The gas from the bladder wall is dissipated via the circulatory system or by rupture of one or more of these small vesicles, with subsequent discharge into the bladder lumen. The bladder may become outlined by air, and anomalous structures (such as diverticula if present) may be visualized on the plain recumbent film of the abdomen. If the ureterovesicular junction is incompetent, air may ascend and outline the calyceal structures of the kidneys.

Cystoscopy may show, as in this case, multiple silvery globules having the appearance of air cysts, cystitis cystica.

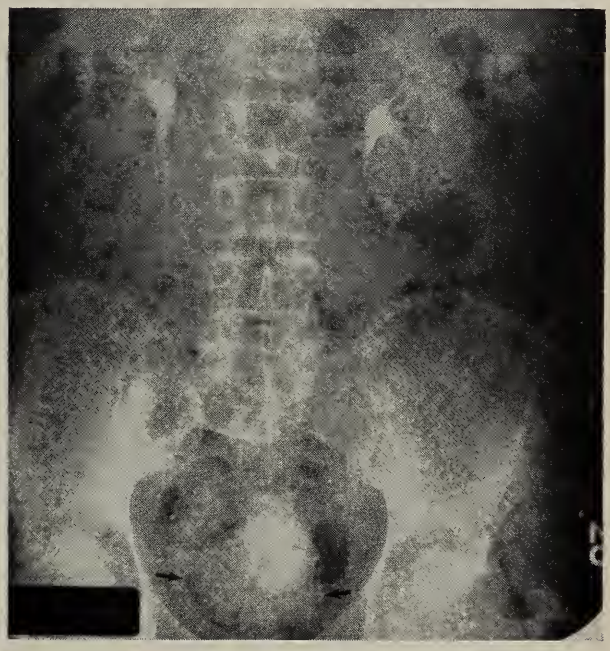


Figure 3. Intravenous pyelogram.

Fetal sex test

Curiosity about the sex of the fetus appears to be about as old as humanity itself if we may judge by the myriads of tests which have been proposed over the centuries for the prediction of sex. At long last Fuchs and Riis of Copenhagen have developed a method of determining the fetal sex beyond any question by examining the cells of the amniotic fluid. But, as the authors point out, the hazards involved militate against its use in clinical obstetrics. *Nicholson J. Eastman, M.D. Prenatal Determination of Sex. Obst. & Gynec. Surv. 15:636, 1960.*

Buzzy, the Cat with Lung Flukes

A story to emphasize that golden opportunities lurk in the shadows about us

Edwin F. Hirsch, M.D., *Chicago*

Father and Mother in the late summer of 1905 decided to move the family from a home on the West Side of Milwaukee to a ten-acre tract of land on the Watertown Plank Road just west of the corporate limits of Wauwatosa, Wis. The ten-acre tract jutted into the much larger acreage used by Milwaukee County for several public institutions, among them the County Poor Farm and the County Hospital. My parents joined in the purchase of this property with a sharp business friend whose shrewdness in the evaluation of real estate enabled him to discern advantages not appreciated by others. The prospect of capital gains in the appraisal of the tract of land rested upon the idea that the county at some time would need this intruding piece of real estate. Another latent value was in the portion along the highway which had been plotted into a subdivision for residential purposes. Years later, this was its ultimate use.

The subdivided land was crossed by two dead-end streets. One was near the east or village boundary of the property; the other was toward the west boundary and opened to the highway opposite the entrance to the County Poor Farm. Three old residence buildings were on the one-acre rectangular strip of land which lay between this street and the west boundary of the ten-acre tract. The largest of these buildings, located about fifty feet from the highway, was in poor shape. Besides repair, the house needed the addition, at the rear, of a kitchen, an upstairs bedroom, a basement laundry, a rear entrance, and a small self-service bathroom on the first floor for a tub that drained its effluvinms onto the lawn. A hand-pumped well for all needs was drilled outside of the rear entrance to the house. The second building, about two hundred feet behind the first, was a small cottage of two rooms with an attached lean-to shed. The third building was an old dilapidated small residence directly east of this cottage. It faced the dead-end of the subdivision street which opened to the highway opposite the entrance to the county farm.

A field garden behind the one-acre tract of land with the three buildings, extended to the bank of a bayou of the Menomonie River. The east border of the field garden merged into terrain that sloped abruptly down and into a slough. Years before, a dam had been built nearby across the bayou to shunt water into a mill race for a small gristmill in the village. The first portion of this old mill race, in disuse, had become a boggy slough, through which flowed a sluggish stream of water. Roughly estimated, the northeast quarter of the ten-acre property was land with a steep slope and land more or less submerged by water of the old mill race. The significance of the slough in the sequence of events will become obvious as this narrative develops.

The decision to purchase this real estate property was influenced also by the practical considerations that the family would have an inexpensive home, the produce of a large garden, and products which are derived from chickens, a cow, and human energy supplemented by horse power, at that time engendered with hay and oats, rather than as now, by gasoline and oil. These advantages as envisioned could make the family almost self sufficient. Construction of the additions to the residence and of a small barn for a cow and a horse were in mid-stages when on Oct. 1, 1905, the family moved from Milwaukee. Most of the household furniture and Father's books were stored in the small cottage and in the dilapidated building, later used for chickens.

The fall weather was superb. Glorious warm days of sunshine, cool nights, and little rain to

disturb the delight of almost total out-of-door life linger with me in beautiful memory pictures. Father rode to his work in Milwaukee on the streetcars which stopped for passengers at the entrance of the County Poor Farm. Mother toiled with the affairs at home, cooked food and baked countless loaves of bread which disappeared under the impact of our ravenous appetites whetted beyond control by the exercise and outdoor life. Of two older sisters, Delia, the oldest in the family and the guardian angel, for health reasons at this time stayed at home. Irene, the other sister, also commuted on the streetcars to her work in Milwaukee. A sister, Selma, between these two, was married to Doctor Frederick G. Henke. They were engaged in missionary and educational work along the Yangtze River in China. Helen and Lora, two younger sisters, entered the grade schools in Wauwatosa. I have replied to scurrilous questions about survival in this medium of femininity with the remark that I held back the younger pair of sisters while dodging the onslaughts of the older three. This remark, of course, is facetious because our family in joy or in sorrow, in ease or under stress, formed a closely-knit unit of strength.

The rebuilding of the residence was finished late in November. On Thanksgiving Day the furniture in storage was dusted off and moved into our house, and a grateful family settled down to a larger experience of living.

I had worked in the West Allis shops of Allis Chalmers Co. for about two years and in the autumn of 1905 was a steel clerk in the forge shop. The walk to and from West Allis across the countryside in the morning and in the evening, each a trip of about four miles, seemed no hardship and daily saved fifteen cents in car fare. When the weather was inclement, or the snow deep, the streetcar afforded transportation; or sometimes Mother with the horse and light wagon would be pressed into service.

While working at Allis Chalmers and still living in Milwaukee, 1904-1905, my father, a former president of a small Methodist College at Charles City, Iowa, which later merged with Morningside College at Sioux City, had tutored me through eight subjects required for entrance to college. Looking ahead to a college or university experience seemed ominous to me, but the decision was made to enter Northwestern University in the fall of 1906.

I arrived in Evanston a timid, confused freshman with $240 in savings, a solid moral support by the family, and a quiet determination. When a small fraction of my suppressed apprehensions escaped into the ears of one of the educators, he remarked properly that the curriculum outlined at Northwestern was not designed for students who required outside work in order to provide the necessities for life at school. However, I soon learned that a great many other students had financial problems like mine and managed to survive.

The strenuous freshman year at Evanston was followed by the decision to become a physician. Dissatisfaction with the quality of training given during the next year in a small medical school in Milwaukee prompted my return to Evanston in order to finish in the liberal arts before continuing the training in medicine. The program of earning tuition fees during the summer and of waiting table for meals and of working at jobs for other expenses during the school year at Evanston solved my financial problems. The $240 in reserve functioned as a revolving fund. The decision to become a doctor made a great difference in my enthusiasm at school. Nothing after that decision seemed too difficult, and the courses of study at the university charged me with a driving interest.

Zoology and chemistry, in the biological sciences, stimulated me profoundly. Prof. William A. Locy, chairman of the department of zoology, gave his course in general zoology to a large class. Professor Locy was built close to the ground, was a stocky man with a short neck, a rather large head, and a round face with short sideburns. Nothing but dignity emanated from his appearance and attitudes; humor was a scarce item. He could draw symmetric figures simultaneously with both hands, and turned his gaze upward at an angle, or elsewhere, as he lectured with solemn precision. We in the class suspected that he might be reading his notes or material off of the ceiling or other surfaces of the room. Breaking out of such a detached discourse with a sharp click made by snapping his tongue from the roof of his mouth, he would step to the blackboard and clarify his lecture material with script or by drawings. A student in this course had better memorize the table of contents in Locy's "Biology and Its Makers" if he desired to achieve any success in the final examination. The profes-

sor, in one of his lectures on comparative anatomy, really startled the class when he designated a small, two-inch specimen of amphioxis as "gigantic." Tardiness in attendance to his class aroused an anathema, provided a student succeeded in passing the locked entrance door. "I will have your registration cancelled," declared he to a visitor who had penetrated the barrier. But quickly the professor became profoundly apologetic when he realized that a former student, not one currently enrolled, had returned to pay grateful respects to a beloved teacher.

The family at home, in the meantime, had settled to a marginal urban form of life on the tract at the edge of Wauwatosa. The lawn about the house was defined, and the gardens were in cultivation. Most of the other land plotted in the subdivision was in hay grass or alfalfa, and the portion of land with the sharp slope to the old mill race and in the slough was a pasture for the cow and the horse.

Early in the spring of 1906 a litter of four kittens was found under a pile of old lumber. One of these, a female, grew up as a pet cat and we named her "Buzzy." Buzzy, when about a year old, developed a peculiar choking cough. The cough became severe and the cat grew thin. Mother was disturbed about having a sick animal as a pet, and thinking that the cat might be tuberculous, decided that Buzzy must be exterminated. So in the summer of 1908, Buzzy and a load of stones in a gunny sack were dropped from a small bridge into the waters of the bayou.

To the amazement of the would-be executioners, the impact of the load of stones on the water tore the bag, and the cat, surfacing from this forced plunge, streaked for the shore and dry land. Having saved an indeterminate number of her lives, she disappeared for several days, but then returned with her cough to the original status of a family pet. However, an order for her execution, signed and sealed by Mother, awaited my return from Evanston for the Christmas holidays (1908). Under this directive, Buzzy received a lethal dose of chloroform.

Now I made a decisive decision entirely oblivious of the circumstance that a proper choice would yield "gold" while the other would yield only "dross." Will I take the dead animal by the tail and give the carcass a great "heave to" down the slope of the pasture, or should a curiosity about the cause of her cough be "fed fat?" There was no hesitancy. Even before the lethal dose of chloroform was given, the decision to explore had been made.

When the lungs of the cat were exposed, the base of each had several cystic nodules, altogether six or eight, and each contained two of the lung fluke parasites. The flukes were soft, red-brown in color, rather smooth, about 11 mm. long, 4 to 4.5 mm. wide and thick. They were bluntly rounded anteriorly, more pointed posteriorly, flat on the ventral surface, and rounded dorsally.

The parasites were preserved in a small bottle containing 70 per cent alcohol and after my return to Evanston were presented to Professor Locy with the query "what are these?" The dignified Professor gazed at my bottled specimens, looked obliquely upward and outward, but not finding a solid answer, suggested that I send the vial with its contents to his friend, Prof. Henry B. Ward, the well known animal parasitologist, at that time in the department of zoology at the University of Nebraska.

Ward promptly identified the specimens as lung flukes (Paragonimus). He had published, in 1894, the first account of the occurrence of the lung fluke in a mammalian host in North America. This was also in a cat, in Michigan. Professor Ward expressed a great interest in my observation, inquired about the host, where the cat had lived, and then mentioned that this parasite had been found only a few times in the United States—in the dog, the cat, and in swine. However, human infestation with lung flukes is common in the oriental countries of Formosa, China, Japan, and the Philippines.

Buzzy on March 25, 1908, had produced a litter of three kittens. One of these was given to a friend in Milwaukee; the other two, a male and a female, grew up with the mother. When the female kitten was several months old, she also developed a choking cough which grew worse and the cat became thin. She was chloroformed on Easter Sunday in 1909, and again cystic nodules containing lung flukes were found in the base of the lungs. The male kitten, surgically separated from his masculinity when small, also had identical symptoms. Chatting about these cats with a veterinarian, across the counter of a restaurant in Evanston where I worked for meals, I told him of the problem of keeping this coughing pet at home. He suggested that the cat be sent to his small hospital for animals in Evans-

ton. This was done and about a month later the veterinarian friend called me to say that our pet had died. We found that the lungs of this cat also had the cystic nodules with the lung flukes.

Doctor H. B. Ward in 1908 moved from the University of Nebraska to Urbana to be chairman of the department of zoology at the University of Illinois. Locy and Ward were close friends. Without doubt, correspondence had been exchanged concerning my interest in the cat disease. A letter from Professor Ward in the spring of 1909 invited me to meet him at the University Club of Chicago. Further correspondence brought about my first personal acquaintance with this dynamic parasitologist. We agreed to his proposal that I go to Urbana a year later on a fellowship, in the fall of 1910 after my graduation at Northwestern, to study the life cycle and establish, if possible, the intermediate hosts, including the definitive infectious stage of the lung fluke.

At home, meanwhile, gossip about the cat disease had spread into the neighborhood, and rumors of other coughing cats in the village reached the family. One of these rumors proved to be real; and in the summer of 1909 parasite eggs characteristic of the lung fluke were found in the excreta of a cat that had been obtained from a family living about three miles away. The cat shortly after was shipped to Urbana in order that it could be kept under observation for further manifestations of the disease and with the hope that later it would provide parasite eggs for studies into the life cycle of the parasite. Alas, the fall of 1910 was too far away! After having arrived at Urbana, the cat escaped into the wide open spaces, carrying away the precious lung flukes that produced the eggs which I had hoped to use in my studies.

Ward stated in a publication later that the two kittens and this cat were the first cases in this country, at that time, in which the presence of the lung fluke was diagnosed in the living animal and in the one was confirmed by the identification of the eggs in the excreta. He also remarked that the family of mother cat and kittens were the first on this continent for which the place of birth and infection was positively determined for the host.

The year 1910 to 1911 was spent in the zoology laboratory under Prof. Ward in a study of the morphology of lung fluke specimens which he had in his collection. H. B., his abbreviated name in the laboratory, had a small framed motto on the wall of his office. It read, "A cordial greeting is not an invitation to stay all day." At the end of the year, the University of Illinois awarded me the Master of Arts degree in zoology (a symbol of the gold). Among the graduate students in Ward's laboratory at that time was George R. La Rue, who finished then the requirements for a Ph.D. degree and shortly thereafter joined the department of zoology at the University of Michigan. D. J. Ameel, one of his students, identified eggs of a lung fluke in the excreta of a neighborhood cat which was being used for other studies.

This source of lung fluke eggs enabled Ameel to work out the life cycle of the parasite. According to his studies, eggs of the parasite shed in excreta dropped in moist soil incubate in warm weather. A ciliated larva, the miracidium, develops in the egg, hatches out, and swimming freely in the water, enters a snail, the first of two intermediate hosts in the life cycle of the parasite. The miracidium larva passes through several metamorphic stages in the snail. These are the sporocyst, the first and second generations of rediae and finally the cercaria stage. The cercaria form has a short tail and, emerging from the snail, moves in the water with undulant motions much like a leech. With nature providing, the cercaria penetrates a fresh water crayfish, the second intermediate host in the life cycle of the parasite, and becomes the encysted metacercaria. This is the dormant infective stage for the definite host, similar in this respect to pork infested with trichina larvae. An animal susceptible to infestation, such as the cat, eats the raw crayfish or crab meat as food. The lung fluke larvae, liberated in the intestinal tract, enter the tissues, migrate, and develop in the host, and become the encysted adult form in the lungs and other viscera. Ameel reports that among trapped muskrats and mink, 16 to 17 per cent were found to harbor the adult lung flukes.

The narrative now returns to the slough in our pasture at Wauwatosa. The natural terrain there was suitable to afford living quarters and food for muskrats and other forms of wild animal life. Muskrats built their huts in the marsh and were trapped there with some success. The slough in the pasture served as a reservoir with all of the requirements necessary for the com-

plete life cycle of the lung fluke. There were the snails, the first intermediate host; the crayfish, the second intermediate host in which the final infectious larvae encysted; and the muskrats, the definitive or final host. Here then, nature had created the favorable elements of environment; had gathered together the required hosts; and had introduced into these environment and host factors the lung parasite where it could live and propagate itself.

Zoologists, and especially those in the field of animal parasitology, are amazed by the morphologic adaptations and by the complexity of the requirements necessary for reproduction that occur among these metazoic parasites. Their germinal tissues have supplanted other organ systems totally or partially; and changes occur even to where both male and female sex glands are in a single parasite. Tapeworms, in which each segment is a complete egg-producing unit, are extreme examples of this adaptation. An interruption of the life cycle of a parasite in any phase of its intermediate state of reproduction is catastrophic.

There is no doubt that Buzzy with a strong taint of the wild in her nature prowled the fields on her own for food. The meat of crayfish could have become delectable morsels, tidbits which she relished and carried back to her growing family of kittens. The decision to do more than to fling Buzzy's carcass down the pasture slope and the subsequent advantages that accrued because curiosity was fed fat, is reflected in this quotation

> "There is a tide in the affairs of men,
> Which taken at the flood, leads on to fortune;
> Omitted, all the voyage of their life
> Is bound in shallows and in miseries."

The threads of curiosity and observation woven with those of imagination by patient industry, fashion the fabrics of life, which in the end yield a great sense of satisfaction, regardless of the field of endeavor.

Thyroid disease

It appears that within the syndrome of familial hypothyroidism and goitre, first described over sixty years ago by Osler (1897), there are at least five biochemically distinct diseases. The clinical similarity of the patients derives from the fact that each biochemically distinct abnormality retards or inhibits at a different stage the process of thyroid hormone formation. The result is compensatory hyperplasia of the gland and clinical evidence of inadequate thyroid hormone supply. In some of these conditions the inhibition of hormone synthesis is complete; in others it is only partial. In at least two of these diseases the enzymatic defect has been demonstrated in tissues other than the thyroid gland. In these cases the disease emerges as one of the thyroid only because of the dominant importance of the particular enzyme in the processes of hormone formation.

At least two of these diseases illustrate the interaction of the genetic endowment with the environment in the production of disease. Both in the dehalogenase defect and in the iodide trapping defect a sufficient ingestion of iodide causes the manifestations of the disease to vanish. In order for the disease to appear not only is the specific constitution necessary but the environment must be appropriate as well. One suspects that iodide deficiency, so long recognized as the cause of endemic goitre, might in certain instances be the result of a mild environmental deficiency of iodide playing upon a constitutional defect common to the people of a particular area.

There is accumulating evidence that definable constitutional defects may play a role in the origin of simple and nodular goitre. Thus many of the relatives of typical cases of the five types of familial goitre also have goitre without evidence of hypothyrodism, and in at least one type, the dehalogenase defect, the goitrous relatives were actually found to share partially in the dehalogenase defect and were presumably heterozygotes. With refinement in techniques for measuring specific enzymatic activity *in vivo,* as by load tests, it will be possible in the future to recognize many types of nodular goitre and to apply specific biochemical tests in diagnosis. *John B. Stanbury, M.D. Constitutional Factor in Thyroid Disease. Proc. Roy. Soc. Med. Nov., 1960.*

Influences on the Rate of Growth of Expenditures for Voluntary Health Insurance

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(*Continued from the January Journal*)

A firm may have a program of benefits that attempts to cover a larger portion of the more expensive hospital bill than the physician's bill for medical and surgical services. If this is so, it may be to the advantage of some physicians to place the individual patient in the hospital where most if not all of the bill is covered by the industrial insurance plan. The patient receives the needed service at little cost to him. It also frees a certain portion of the patient's funds to pay the physician's bill for services outside the hospital. The way in which the hospital benefits are constructed, therefore, can result in a rise in expenditures of the employer.

These economic factors go a long way to explain the rise in medical care expenditures.

The highest of the indexes for medical care was the hospital index (Figure 4). Part of the rise in hospital charges (Figure 7) is due to a combination of sociomedical factors. Among the key factors are:

A. The scientific revolution in medicine

Based on his experience with the Rockefeller Foundation, Dr. Allan Gregg pointed out that it was only by 1910 that enough physicians had enough knowledge so that one could be called at random and probably do better than he would have had he not bothered at all. In less than 50 years there has been an intensified advance of medical knowledge, so that the average patient who sees the average physician today will be much better off than he would have been had he not seen a doctor at all. Evidence of this can be seen in the greater expectation of life at birth: in 1900 about 50 years, now about 70.

It must be mentioned that for the aged person who now is 65, the expectation of life is barely two years more than it was in 1900. Old people are not living to be much older, but many more people are living to be old. This is due primarily to a series of victories by medical science and public health over acute infectious diseases. In 1900 the five leading causes of death were pneumonia, tuberculosis, diarrhea, heart diseases, and kidney diseases. Today heart diseases, cancer, violence or accidents, apoplexy, and kidney diseases are the leading causes of death.

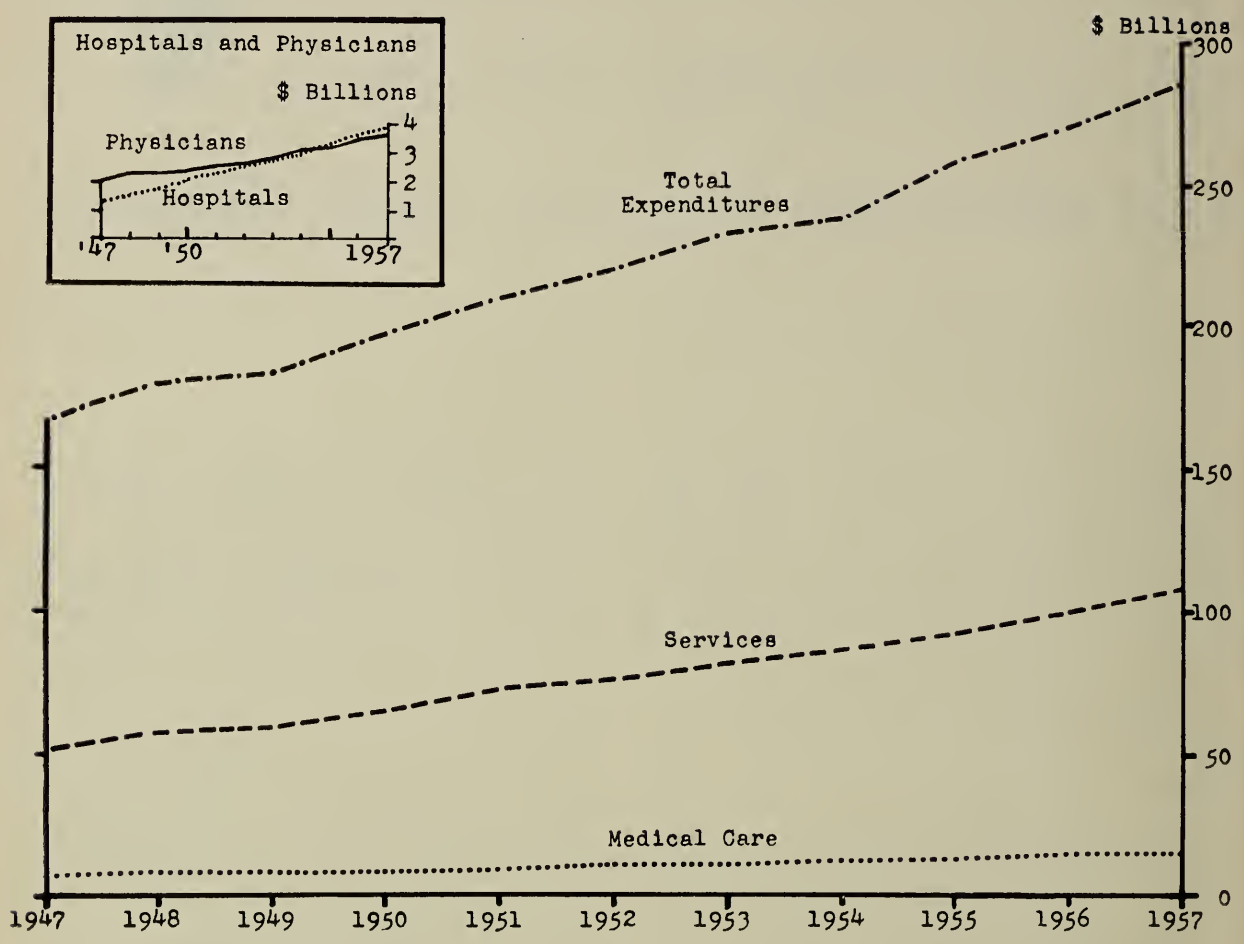
With our greater knowledge of the many diseases a patient might develop has come the intricate problem of diagnosis. We know more about diseases today, and we know more about handling specific diseases. The time, equipment, and personnel needed to make a proper diagnosis all contribute to the higher cost of medical care.

B. Only the best is good enough

As medical science has devised new means of treating disease and prolonging life, there has been an augmented awareness of the usefulness of medical services. A rising standard of education has led to better health education for much of the industrial working population. A consequence of this high public evaluation of medical care is the drive of many people to seek only the best that money can buy. In order to get the best care they use the hospital, which,—to the public—symbolizes miraculous cures because the

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Figure 7. Total personal consumption expenditures and expenditures for all services, medical care, hospitals, and physicians, 1947-1957



Source: U.S. Department of Commerce

latest medical knowledge and the best equipment are available there. At one time the hospital was a place where the physician placed the patient for him alone to see. Today, the hospital is a place where the patient goes so that he can be seen by a series of medical specialists, all of whom contribute to his well being.

C. Rise of the medical professional specialists

To properly implement all of the techniques of modern medicine, new classes of medical technicians have been created. In 1920 there were fewer than 150,000 physicians and surgeons in the United States; today there are more than 200,000. In 1920 it was estimated that there were 450,000 persons in other health professions; in 1953 according to comparable estimates, there were 870,000 (Figure 8). Hospital managers

Figure 8. Number of health workers (including physicians) and number of physicians in the United States in selected years, 1900-1950

Year	Number of Health Workers (Including Physicians)	Number of Physicians
1900	234,708	
1906		121,484
1910	354,754	
1920	458,645	
1921		145,404
1930	660,788	
1931		156,406
1940	749,288	175,163
1950	1,009,865	201,277

Source: Data on health workers from National Manpower Council, A Policy for Scientific and Professional Manpower, Columbia University Press, New York, 1953. Data on physicians from American Medical Association.

listed at least 180 subdivisions of services in hospitals. A few examples of the personnel who provide these services are: registered nurses, nurses' aides, attendants, medical technicians, psychotherapists, occupational therapists, physical therapists, social workers, dietitians, and hospital administrators. The more subdivisions of medical care necessary to handle the patient properly, the higher the charges by the hosptial to the patient and to the prepayment system.

D. Use of the hospital by physicians

Even though during World War II approximately 40 per cent of all active physicians were in federal service, it was impossible to find evidence of deterioration in the level of medical treatment given the population. As civilian physicians worked longer hours, they made greater use of hospitals to increase their efficiency, just as physicians in service did. Increased hospital utilization carried over into the post-war years.

At the same time, there were more hospitals to be used. Under the Hill-Burton program, units containing approximately 152,000 beds were built through a combination of public and private funds either to replace existent facilities or as new construction. Additional units, containing an equal or greater number of beds than those constructed under the Hill-Burton program, were built by private means. This provided physicians with the necessary equipment to treat patients as effectively as possible.

E. The dynamic changing nature of the hospital in an inflationary period

Many persons in the early part of this century thought of the hospital as a place in which to die. Now the hospital provides an immense range of facilities for diagnosis and treatment. In the process of providing care for patients, many large hospitals engage in research, thereby adding to their knowledge of disease while developing useful diagnostic techniques. All this is done in the interest of providing good care.

To handle the new diagnostic techniques, special arrangements for special diagnostic categories of patients have been made within the hospital. As an example, the first psychiatric unit in a general hospital in the United States was introduced in the 18th century. The second was not constructed until the turn of the 20th century, and in 1945 there were less than 250 such units in the United States. Today there are approximately 500 to 600 of these units in general hospitals. Since the hospital is now handling the problems of the chronically ill and the long-term patient, the result has been increased hospital expenditures met largely from patient income.

Although it is true that there are more hospital admissions, and that on the whole the average patient stays a shorter time, the nature of the present day hospital stay gives rise to increased expenditures by the prepayment system. Patients are getting well faster, but charges usually are high during the early days of a hospital stay when so much diagnostic work is done. Advanced medical technology encourages physicians to make as specific a diagnosis as possible. This often means additional expenditures of time and money by physicians and hospitals, resulting in higher expenditures by the patient.

Furthermore, hospitals have been caught in the general inflationary spiral. The average per diem expense for a semiprivate room in a voluntary short term general hospital went from $10.-04 in 1946 to $26.81 in 1957 (Figure 9). For firms located in New England or on the west coast, the per diem hospital expense is even higher (Figure 10). The things hospitals buy today cost more, and the newest x-ray equipment is extremely expensive. The rapid advances in medical science have created a demand for improved medical equipment, most of which has been purchased since 1946.

Figure 9. Average per diem expense for voluntary short term general and other special hospitals, United States, 1946-1957

Year	Expense Per Patient Day
1946	$10.04
1947	11.78
1948	14.06
1949	15.14
1950	16.89
1951	18.01
1952	19.55
1953	21.09
1954	22.78
1955	24.15
1956	24.99
1957	26.81

Source: American Hospital Association, Hospital Costs —A National Review, address by Madison B. Brown, M.D., Associate Director, presented at the 60th Annual Meeting of the A.H.A., Chicago, August 21, 1958.

In addition to the general inflationary trends, hospital charges have been influenced by their particular industry problems. The high demand for labor by industry has added to hospital expenditures. A study of New York City hospitals by Dr. Henry M. Pratt, of the New York Hospital, showed that approximately 70 per cent of hospital expenditures are for wages and salaries. During the depressed 1930's it was not difficult to obtain personnel to work in the hospital, but since industry now demands a greater share of the civilian labor force, the hospital has had to pay higher wages to get sufficient help. The majority of hospital employees are female, and industries' demand for women workers has increased also.

As Dr. Pratt's study shows, because of stepped up productivity in industry and regulatory legislation, the number of hours in the work week has decreased steadily. In hospitals, however, a working force must be present 168 hours a week, 52 weeks a year. Not many years ago the average hospital employee worked 54 hours a week, and 3.1 employees were required to cover one position for 168 hours; with the current 40 hour week for employees, 4.2 persons now are required for each position and they receive higher wages.

The increased labor costs can be explained simply on the basis of competition with industry for employees at higher wages, but the increase of medical technicians has compounded this increase. A study of 10 Maryland hospitals between 1948 and 1957 showed that while general expenses rose 75 per cent and food costs 50 per cent, nursing costs went up 174 per cent and medical and surgical expenses increased 236 per cent. As noted before, medical and surgical expenses are increasing because of greater utilization of certain services and improved technology as well as rising labor costs. In the area of the laboratory and radiology departments, the increase has been major. The Maryland study indicated that expenses for the operation of these departments were multiplying at a substantially faster rate than the rate of increase in usage of these departments because of improved technology and higher personnel costs. In the category of medical and surgical services, salaries in these hospitals amounted to approximately 60 per cent of total department expenses in 1957.

Indirectly, the hospital has been affected by the impact of inflation on local government. Because they have had to pay more for other services, some local and state governments have not paid their fair share of the increasing costs of providing hospital care for all indigent patients. The hospital has had to absorb, in some cases, practically the whole cost of providing hospital care to the indigent. The Kentucky Medical Society reported that many of the medical and hospital services needed by the indigent have been provided gratuitously by the physician and hospital. The failure of many local governments, because of their financial condition, to pay their fair share of such costs has increased the financial problems of the hospitals and, to cover the deficit, charges to other patients have risen.

Figure 10. Average length of stay and average expense per day, by region, 1957

Region	Average Stay	Average Per Diem Expense
New England	7.9	$30.76
Middle Atlantic	8.7	25.77
South Atlantic	6.8	23.87
East North Central	7.6	27.59
East South Central	6.4	24.40
West North Central	7.7	22.89
West South Central	5.9	26.26
Mountain	6.2	26.06
Pacific	6.0	35.33
AVERAGE	7.4	26.81

Source: American Hospital Association, Hospital Costs —A National Review, address by Madison B. Brown, M.D., Associate Director, presented at the 60th Annual Meeting of the A.H.A., Chicago, August 21, 1958.

F. Social causes of utilization due to the labor force.

While there are many ecologic reasons for use of medical services by the labor force, I have selected three which might have some bearing on the increased expenditure for the insurance industries provide for their employees. The first interrelates with the increased labor force, most of which is concentrated in urban areas. There is a greater utilization of hospitals and physicians in these areas, and as more of the labor force shifts from rural to urban settings, fringe costs for medical, surgical, and hospital benefits may go up.

Second, with more employees, accidents are more likely to occur. A recent AMA survey found that 7.5 per cent of all patients in hospitals were there because of accidents, so the increased num-

ber of home and auto accidents has added materially to the costs of companies' medical care programs.

Third, the seniority of industrial employees has increased. If many of these employees are middle-aged, these employees (and their wives) generally require more medical care than do younger persons. A recent study in New York shows that there has been a significant increase in hospital utilization by males when they reach the late 40's and early 50's. Since the average employee today may be older, better informed regarding medical care, and more likely to seek it if he has health insurance, increased expenditures for medical care are to be expected.

Although other reasons for increases in medical care expenditures might be mentioned, these key economic and social forces may give some insight into the reasons for increased expenditures to any particular firm. Perhaps we should attempt to make some estimates on how these trends may affect the medical care expenditures particular firms may make in the near future.

Effects on future costs

As I have said, economics received the name of "the dismal science" because of its attention to the realities of the situation. One of these realities is that over-all expenditures for medical, surgical, and hospital benefits in the near future will continue to go up so long as there is a general inflationary trend in the economy, industries add more employees to their labor forces, and as industries broaden the benefits to be provided.

The main hopeful sign regarding expenditures is that the per capita costs for medical care probably will not continue to increase as fast as they have in the past 10 years. Some influences in cutting this rate of increase are:

(1) Service prices, including medical and hospital prices, now bear the same relationship they did to other prices before 1940. Since part of the rise in service prices served to eliminate the lag between them and other prices, the rate of increase of all of these prices will be similar to that of the general economy.

(2) Good health generally results from a combination of proper nutrition, mental attitude, and possession of certain knowledge regarding health care. When the population as a whole adopts better health habits, the incidence of some diseases probably will decline. One of the things to be expected from the industrialization of the South and the West is that the higher income level will enable the employee to be better nourished, thereby bringing about a decline in some disease rates.

(3) Most industrial employees will have an improved continuum of medical care. Due to improved standards of health education, more individuals will have their illnesses treated in the early stages, when they are more responsive to treatment and less costly. This does not mean that there will be a decline in the use of hospitals for treatment of illnesses, but hospitals will be used less often for many diagnostic procedures. Although the hospital has a huge concentration of diagnostic facilities, there is every reason to believe that more diagnoses will be made in physicians' offices. Since the charges for diagnostic procedures add much to a hospital bill, industrial medical expenditures could be reduced if more diagnoses were made outside the hospital.

(4) Aid in controlling rising medical care expenditures can be given by physicians. Recognition of the role the physician must play is seen in a recent statement of Dr. Gunnar Gundersen, past president of the AMA: "The profession and all its members must be vigilant to see that other factors do not help to raise medical care costs; at least, we must exercise as much control as possible over these items we can directly influence. We must guard especially against the abuse of overprescription, overutilization, and overcharging simply because the patient happens to have insurance protection."

(5) In some areas of medical care, there is a near maximum utilization of hospitals. To illustrate: In 1935 only 37 per cent of all live births occurred in the hospital, while today over 93 per cent of all live births occur there. Since over 93 per cent of all babies are born in hospitals, there is not much likelihood of increased expenditures resulting from this type of medical care.

(6) Although an extension of the benefits provided by medical care plans will increase firm expenditures in the short run, in the long run it may result in decreased expenditures. The present type of voluntary health insurance is primarily hospital oriented; in many cases, it is necessary to enter the hospital to receive benefits under a plan. As more plans provide nonhospital

benefits, more patients will be treated outside the hospital and this could lead to a decrease in overall expenditures.

Many firms have already accepted the responsibility of providing safety programs and health care for their employees at work. To the extent that these programs are extended, in cooperation with the physician in the community, to cover more phases of preventive medicine and health counselling, the future rate of increase of expenditures for medical care away from work will be diminished.

Most medical expenditures have risen in the 1950's due to basic inflationary changes in the economy. The future rise in these medical expenditures will be determined by these inherent economic forces as well as by the desire of the people to obtain more and more medical care. There is a limit to what the demand for medical care will be. Employee demands will not continue indefinitely in this area but will move into other areas of collective bargaining. At least, the expenditure of firms for this fringe will not go up as fast as it has in the past, assuming we do not have another surge of inflation.

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Too many of us, when we accomplish what we set out to do, exclaim, "See what I have done!" instead of saying, "See where I have been led."—*Henry Ford*

EDITORIALS

Infectious mononucleosis— Is it a "college" disease?

Infectious mononucleosis remains unpredictable; the cause is unknown, transmission is uncertain, and therapy is controversial. Although it is self-limited, it may be devastating in terms of a college career.

Is this really a college student disease, or does it occur in children and adolescents? On reviewing college statistics, incidence seems to bear a direct relationship to the number of blood counts done. For example, in 1945, 29 cases were reported; in 1960, 111. The same university, the same population, the same physicians; but a laboratory had been added.

During this school year, 20 college students out of 1,000 will have it. Of these, 70 per cent will need either hospital or infirmary care and will remain there from one to thirty-two days, an average of eight days per patient. Because of this illness, about 6 per cent will withdraw from school for a quarter. This poses a problem to student and educator alike. The significant peak of incidence in a midwest university occurs in May.

Although the cause of this illness is not certain (Students refer to it as a stress and strain disease.) a virus, or less commonly, Listeria and Toxoplasma all remain suspect. The transmission is thought to be by close oral contact such as a kiss, a shared tooth paste, and shared pipettes. Fomites are also incriminated. An incubation period of 25 to 60 days has been postulated. The fact that only 20 out of 1,000 students living closely together in a co-educational university contract this disease strongly suggests that a high proportion of the population must become immune prior to college age.

This is a systemic disease. The most frequent targets are the lymph glands, spleen, liver, pharynx, and on rare occasions, the central nervous system, lungs, and myocardium.

Mononucleosis may present itself with a high spiking temperature exhausting both the patient and the physician, or a membranous throat, which could be diphtheria, or with right lower quadrant pain simulating appendicitis or ovulation, or a rash which could be rubella. Certain physical findings may be helpful in making a diagnosis. Among these are a small posterior cervical or axillary lymph gland which becomes larger day by day, the development of petechiae on the palate, puffy eyelids, a spleen extending beyond the costal margin, or the presence of a tender and enlarged liver. The diagnosis may be confirmed by finding atypical lymphocytes or by the presence of a positive heterophile antibody test using the guinea pig kidney-absorbtion technique which increases the reliability of this test. Unfortunately, these laboratory findings may remain stubbornly normal until the patient is improved; therefore very often repeated blood counts and heterophile tests must be done to confirm clinical suspicion. Transient atypical lymphocytes are found in other viral diseases, especially rubella and infectious hepatitis.

Therapy depends upon the individual patient. Bed rest is most desirable during the acute phase in the presence of chills or fever, in the presence of anorexia or pharyngeal involvement, an enlarged spleen, or liver disability. However, one finds mild cases in patients who remained ambulatory, the diagnosis having been made in retrospect by a chance blood count. These patients have done very well without complications. In severe anginose cases, gamma globulin and steroids have been reported useful. Because

of increased frequency of hemolytic streptococcic and Vincent's organisms in the pharynx, nose, and throat, smears and cultures should be examined. For these secondary infections, antibiotic treatment is indicated. One must be aware of the rare but serious complication of splenic rupture.

Isolation of the patient is controversial. Resumption of activity should be based on the patient rather than the blood counts and antibody titres, which may remain abnormal for months.

At a recent American College Health Association meeting, a "mono" breakfast provided an open discussion of this intriguing disease. It was not regarded as a cause of chronic hepatitis. A physician from a western university believes he can abort the disease by steroids. Dr. Bowie[1] believes prolonged albumin-globulin reversal may be related to the asthenia. Much has been made of the fatigue and apathy associated with mononucleosis; one must be aware of creating an iatrogenic state. In a round table discussion, it was learned that only two universities thought it necessary to rigidly isolate patients with mononucleosis. The possibility[2] of "Mono Annies" in our midst as well as Typhoid Marys was suggested.

Leona B. Yeager, M.D.

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Take my money but spare my life

The increase in malpractice suits is bound to affect the way the physician practices medicine—to the advantage perhaps of the physician and to the disadvantage of the patient. Someone pays for the large awards, and in the long run it is usually the consumer. But from the bad comes good. As one physician summed it up, "I take care in what I do, what I say, and how I say it."

The Boston University Law-Medicine Research Institute conducted a survey among Massachusetts physicians to determine whether malpractice suits had affected their practice of medicine. There was no doubt that it had, according to the director, Prof. William J. Curran.

Many physicians reported an increasing reluctance to accept patients known to have previously sued physicians; those who "shop" around from doctor to doctor; alcoholics; bad credit risks; and those who are "suit prone" in other connections. Many GP's reported that they no longer attempt minor surgery or handle their own x-ray work in fracture cases. Others avoid using newer drugs and prescribe products older and more acceptable even though less effective in some cases.

Some physicians had adopted certain procedures as routine practices. They ordered more x-rays and laboratory analyses to have a tangible record in case of a suit. They insisted on more consultations with specialists to protect themselves. All of these procedures increase the cost of medical treatment.

There was also an increasing tendency among physicians to put things in writing "just for the record." These included operating permits, consent forms for treating minors, autopsy permits, appointment cards (in duplicate we hope), written instead of telephoned prescriptions, detailed case histories and treatment records, and special care in keeping extensive records on uncooperative patients.

But the most concrete effect of malpractice concern was on the physicians themselves: They carried substantial amounts of very expensive malpractice insurance.

We may dislike the implications of malpractice to our security and good name, but it can be combatted by incorporating into the practice of medicine those little extras that take time and add to the cost of care. The concerns of the physicians of Massachusetts should become the concerns of physicians in Illinois. Take their suggestions seriously.

There are some points to keep in mind:

It is good to remember that a well informed and satisfied patient seldom sues.

It helps to explain the illness fully, as well as the method of treatment, not only to the patient but to the family. Be particularly careful in spelling out all the side reactions and potential consequence associated with dangerous therapy.

Good luck! The practice of medicine is still safer today than it was in the dark ages when a mistake cost the physician his hands or his head.

The physician and Blue Cross

The title of an editorial in the Wisconsin Medical Journal[1] caught our eye, "You Shall Not Crucify Medicine Upon a Blue Cross." We recognize the fact that there is considerable friction among the physicians of our neighbor state to the north and their voluntary health plans. Basil C. MacLean, former president of Blue Cross association, is quoted extensively in this editorial. According to Doctor MacLean, Blue Cross must go "beyond merely competing with or imitating the insurance companies . . . . The Blue Cross symbol must mean complete coverage, without any qualifications, for all sources that are provided in hospitals." He also refers to Blue Shield as the "monkey on the back of Blue Cross" and claims that Blue Cross could move faster without it. The latter was one of the sore points in the Wisconsin issue. The Blue Shield monkey finally got off the back of Blue Cross, but the Milwaukee group promptly got another monkey instead of "capitalizing on this freedom—instead of moving faster."

The editorial is blunt and to the point in referring to the shortcomings of Blue Cross. "The truth of the matter is quite simple: commercial competition in the field of prepaid hospital care has cut into Blue Cross enrollment merely because it is able to offer comparable or superior benefits at comparable or lower costs to more people. For years Blue Cross naturally had a toe-hold on the health insurance market. It selected its risk including the elderly, avoiding the less profitable nongroup policies, except at exorbitant cost. At the same time, Blue Cross increased its rates so much that commercial insurance companies could compete at a profit and offer the public coverage that Blue Cross omitted."

Blue Cross and Blue Shield was the medical profession's answer to prepaid hospital and medical care. We are so closely indentified with these plans that their success or failure could well determine the fate of organized medicine. But the title on that Wisconsin editorial still haunts me, "You Shall Not Crucify Medicine Upon a Blue Cross." Let us not get too involved in our ancillary services to lose sight of our primary objectives.

1. Editorial. You Shall Not Crucify Medicine Upon a Blue Cross., Wisc. Med. J., 59:765 (Dec.) 1960.

Real estate offers investment opportunity

Those physicians who have or intend to invest in real estate should have their tax consultants take a look at the new "real estate investment trust" which has recently been enacted into law. It gives those who invest as a group in real estate an opportunity to make tax savings by qualifying with the Internal Revenue Service. Any group of such investors should take a look at this new law.

Reports to the Council

Committee on Nutrition Supplementary Report

The Committee on Nutrition of the Illinois State Medical Society met in Springfield December 9, at the invitation of the State Department of Public Health, to evaluate the 900 calorie weight control formulas and to review their use by the public.

Dr. Lee Fatherree, director, informed the group that the department has tentatively approved several new 900 calorie milk formulas produced by dairies and that these are now being sold in Illinois. He reported that his department is striving for uniformity of labeling on these products. Meantime, physicians can accept the labels to describe the vitamins, proteins, minerals, calories and other ingredients of the products.

After discussing the advantages and disadvantages of this type of dietary product, the committee concluded that these 900 calorie weight control formulas can be accepted as food products, and that they should be used with caution and judgment.

The committee issued a series of precautions to be observed in avoiding the pitfalls of unsupervised reducing diets:

1. These special low calorie formulas are dangerous for long term use.
2. They are not a substitute for a well-balanced diet except for short term weight control programs and are not a good means of saving money or time spent eating meals.
3. Because many of these formulas contain the recommended daily dietary allowances

of vitamins known to be essential, additional vitamin intake could produce undesirable results. Therefore, persons on these diets should not take vitamin pills at the same time. For the same reason, persons on 1800 calorie diets should not attempt to get their calories by taking two 900 calorie formula units because in so doing they also double the amount of vitamins they consume and are subject to vitamin over-dosage.

4. People concerned about being over-weight should not be put on or put themselves on so-called "crash" diets to lose weight too rapidly, A normal, healthy person should not expect to lose more than one or two pounds a week by dieting except on medical advice in special situations.
5. Persons using these formula products as their sole source of nutrition, even for brief periods, should seek consultation immediately if they develop constipation or diarrhea, or other untoward symptoms.
6. The public should be told that any effective weight control program requires a continuing adherence to a properly balanced diet. Formula weight reduction plans can bring about a weight adjustment but once this is achieved it should be maintained by balanced dieting, The Committee pointed out that the average person seldom is truly successful with most dieting programs because once the weight is down to the desired level there is no continued drive to dieting and soon weight gains are resumed.

The Committee recommends that the results of this meeting be made available to all members of the Illinois State Medical Society so they can use them in advising patients of the proper use of the currently popular 900 calorie weight control formulas.

Paul Dailey, M.D.
Chairman, Committee on Nutrition

Second National Conference on the Medical Aspects of Sports

A report of the highlights of the above meeting follows:

A very well planned and executed program was presented. Many well documented papers were presented in panel form. All stressed the importance of the physician in giving proper guidance and supervision to the young athlete.

The first sport discussed was boxing. The hazards of this activity were pointed out, and documented evidence with EEG recordings did not substantiate the popular impression that brain damage is a frequent aftermath of boxing contests. However, serious injury can result. For example, at the University of Wisconsin one of their champion boxers died after a knockout. Other cases were reported with like disaster, even when head protectors and large gloves were used. Because of these unfortunate cases the manly sport of self defense has been abandoned as an intercollegiate sport in some schools.

In the discussion on football it was stressed that in all games a physician should be in attendance to supervise the injured player and determine if any injury sustained should require him to leave the game, temporarily or completely, depending upon the extent of the injury. Here the physician's knowledge of the health of the student, the type of injury, and how it was obtained are very important factors. They help determine not only treatment of the immediate injury, but what should be the follow-up, whether he should return to active play during the game, in a few days, or be completely removed from the squad.

Good coaching and training were considered essential for registered physician educators, but medical knowledge was the determining factor regarding all health and accident problems. Proper and efficient handling of the injured at the time of sustaining the injury was essential; use of efficient litters should be provided more frequently. Proper examining facilities, close to the playing field, should give the team physician a better opportunity to make accurate evaluation of all injuries. The team physician should have consultation available for all situations.

The psychological aspect of athletic injuries was presented with case histories demonstrating situations, such as accident prone factors.

Contact sports for the elementary school were discussed in a small group panel. It was pointed out that chronological age is not always on a parity with growth and development. All children in this group need to benefit by participation in sports to develop skills and muscular coordination. The contest factor and the tremendous stimulus that some adults place on children's athletic endeavors should be played down

and not built up. In some communities the spirit of contest and the importance of winning brings out plans for a Roman Holiday spirit, both entirely out of proportion to original intent of the game.

Women in athletics was discussed from the standpoint of the occurrence of the menarche. It was felt that in the well trained woman athlete this was a small factor in her performance.

One paper was given on the legal aspects of the school athlete injuries, and here a well worthwhile bit of information was given by a physician with a degree in law also. He stressed the responsibility and liability that the physician assumes in treating the injured on the sports field. Today with the public being more suit-conscious, the liabilities of the school team physician are increased. These players are minors and consent must be given for treatment; also a youth may be only 14 to 15 years old, and in some states this youth may sue a physician when he reaches 21 years of age. A case cited was that of a boy and his family instituting a suit against a school board for injuries sustained in a football game. He cautioned the physician to remember that the Good Samaritan attitude has many legal loop-holes; hence, caution and forethought should be watchwords.

Suggestions and outlines were presented on planning conference programs on protecting the health of athletes.

No specific recommendations were made, but this assembly is to be repeated annually.

Respectfully submitted,
EUGENE T. MCENERY, M. D., *Delegate*

Drugs for athletes

A recent issue of Sports Illustrated carried a story on the scientific studies that have been done by various physiologists in the use of drugs by athletes. They are widely used for this purpose around the world. The amphetamines produce as much as 4 per cent improvement for weight lifters, 1.5 per cent for runners, and 1.16 for swimmers. In terms of records, these figures would mean 3.6 seconds off the time of a four-minute mile.

These stimulants reduce the sense of fatigue and despair but can be highly dangerous. This is particularly true when they are used by the hyperexcitable individual or those with cardiovascular disease. The death of an Olympic long-distance runner was attributed to these drugs.

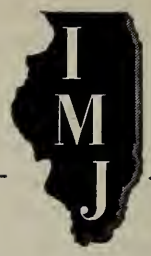
The old saw "Never beat a tired horse" is applicable to the use of stimulants by athletes. They run the risk of serious overstrain because they are not aware of normal fatigue.

If this continues it may be necessary to examine our athletes for "dope" as veterinarians now do horses prior to a race.

Resolutions for House of Delegates

To be included in the HANDBOOK FOR DELEGATES to the 1961 Annual Meeting, resolutions should be submitted to Robert L. Richards, Executive Administrator, by March 1. Resolutions not submitted in time for publication will be duplicated for distribution at the meeting. All members and county societies are urged to prepare their resolutions for inclusion in the Handbook to reduce on-the-spot duplicating.

AT THE EDITOR'S DESK



Pharmaceuticals

Tenuate Dospan is William S. Merrell Company's new addition to the long list of anorexigenic drugs. The Tenuate is diethylpropion, which they claim, "seems to work on the saticty nerve center. A person using Tenuate has the edge taken off his hunger at meal time. It takes a relatively small amount of food to make him feel full." Dospan is Merrell's exclusive time release tablet. Again they claim that, "Dospan almost thinks for itself." It is so formulated that, "there is first a quick release of the drug to bring the medication up to effectual dosage level. Then the Dospan tablet slowly releases Tenuate to maintain this level for approximately six to eight hours."

Wonderful if true.

The value of Bonadoxin Drops in treating infant colic was stressed again in a news release from Roerig that reported the findings of Dr. William D. Little, Jr., who ran controlled clinical tests. He is quoted as concluding, "Bonadoxin . . . is of considerable value in the treatment of infant colic, and . . . early use of this preparation should be considered in appropriate cases."

This combination drug contains meclizine and pyridoxine; it competes with similar products containing barbituates and belladonna.

Student Psychoneuroses

The public information office of the University of Illinois reported that 355 students visited the mental health division of the health service. Four of every five suffered with psychoneurotic and personality disorders. Approximately one-third were counseled for one to two hours and two thirds required continuing psychiatric treatments. Eleven patients were hospitalized.

Another Collagen Disease?

A group from the Cornell Medical Center suspect that a predisposition for scleroderma runs in families and is closely related to other connective tissue or rheumatic diseases. They noted that while only one relative of a scleroderma patient was found to be similarly afflicted, seven per cent were found to have rheumatoid arthritis. In addition, a significant number of the healthy relatives had a positive test for the rheumatoid factor. Their report to the American Rheumatism Association also included the information that 9 of 19 victims of scleroderma showed elevated gamma-globulin levels and antinuclear antibodies which are specific for lupus erythematosus.

There is a good possibility that we will find in the years to come that many of the bizarre and less common collagen diseases are one and the same.

Dimes Returned

The National Foundation supplied the following information relative to the allocation of March of Dimes funds raised in the State of Illinois since January, 1938.

In this period, Illinois' 102 chapters of the March of Dimes organization raised a net total of $29,390,458.87 at an average fund raising cost of less than 12 per cent. Of this amount, $18,229,121.41 has been available to the county chapters in carrying out their extensive patient aid programs, including advances of $4,995,674.18 from the national office to meet local emergency situations.

In addition, grants totaling $2,222,177.85 have been made in support of research and professional education projects at Illinois institutions. Principal recipients of these 115 grants have been the University of Chicago, $932,-

364.13; the University of Illinois, $695,907.47; Northwestern University, $276,404.60; the Brain Research Foundation, $132,313.48; the Chicago Board of Health, $82,324.65, and the Michael Reese Foundation, $75,983.12.

National headquarters' expenditures for the vaccine trials in Illinois amounted to $94,715.46. In addition, the national office has sent into Illinois $249,047.96 worth of Salk vaccine and 663,594 cc.'s of gamma globulin in support of its polio prevention programs.

These figures demonstrate that the lion's share of the funds was used in carrying out extensive patient aid care.

We'll grant that almost $1,000,000 more was spent on fund raising costs than on grants for research and professional education projects. But the Foundation is many times more generous (and we are most thankful) in returning to us the monies collected in Illinois than our Internal Revenue Service. The state gets back about three per cent of the tax dollars that found their way into Washington.

Hospital Food Costs

The cost of preparing patient meals in the nation's hospitals averages $3.64 per patient day, according to a survey reported in The Modern Hospital magazine. Half of the cost goes for food, and the remaining half for salaries and other costs. Feeding patients is one of the largest of hospital operating expenses.

First Checks to Disabled Workers

A release sent out by the Social Security Administration informed us that "this week 104,318 disabled persons — workers under age 50 and their dependents — received their first monthly social security checks." Approximately 100,000 disabled workers under 50 years of age had applied to have their social security records frozen under the 1960 changes in the law.

One of these was a 20 year old polio victim who will receive a monthly disability benefit check of $77. He is the youngest recipient, and his monthly benefit is based on his earnings from part-time work after school and on Saturdays and later from full-time employment in a lumber mill and bowling alley. He is paralyzed at the present time but must apply for rehabilitation in keeping with the law. His monthly checks will continue until he is able to do substantial work. The benefit check will continue up to 12 months after he begins working at his new trade and demonstrates his ability to continue working.

To be eligible, a disabled worker must have a condition so severe that it prevents him from engaging in any substantial gainful activity. In addition, he must have social security credits for at least 5 years of work out of the 10 years before he became disabled.

Advance In Heart Surgery

We note that the U.S. Naval Hospital, St. Albans, New York, has come up with an advance in the realm of heart surgery. A team of officers there, including Commander M. J. Trummer of Villa Park, has developed and improved a heart-lung machine for use during open heart surgery, climaxing nine years of research. It is based on an experimental device built in 1951 at the University of Minnesota and has been used successfully in ten open heart cases.



Left to right: James Kist, Lt. H. S. Pollard, and Cdr. M. J. Trummer with heart machine in the hospital's machine shop. (Official U.S. Navy photo)

Essentially the machine replaces oxygen in the blood and removes waste gases, pumps blood through the body, and cools the blood to lower the patient's body temperature to 50F.

This improved model can now precisely regulate a balanced intake or output of blood, and eliminates the risk of injecting bubbles from oxygenated blood into a patient's blood stream. It requires only five pints of blood versus the 12

pints needed in the old machine. Its size has also been reduced from that of a washing machine to about that of a large suitcase.

Further efforts are being made to reduce the machine's bulk and to develop a mechanism that allows accurate operation by hand. The team's goal is to make it completely portable.

Physician to Population Ratios

We were informed by HEW that the Boston area has the highest ratio of physicians to population (207 per 100,000 people). The San Francisco area is second with 199, and the New York-Northeastern New Jersey area is third with 189. The Chicago, Illinois-Northwest Indiana area is down the line with 143, and the St. Louis, Mo.-Illinois is further down with 132.

The New York-Northeastern New Jersey consolidated area has the highest proportion—77 per cent—of physicians in private practice. The Baltimore area has the highest proportion—38 per cent—in hospital service, teaching, administration, research, and other salaried positions.

State Law Limits Study of Biology

Illinois is one of six states that prohibits all or nearly all study of animals in public schools. According to law, "No experiment upon any living creature for the purpose of demonstration in any study shall be made in any public school of this State. No animal provided by, nor killed in the presence of, any pupil of a public school shall be used for dissection in such school, and in no case shall dogs or cats be killed for such purposes . . . ."

The National Society for Medical Research appeals for your advice and suggestions to aid them in explaining to the public that the study of biology should be limited only by reasonable humane restrictions.

AMA Dues Increase

The AMA House of Delegates approved a Board of Trustees report which announced that a dues increase would be recommended at the annual meeting in June 1961. The report indicated that the amount would be not less than $10 and not more than $25 to be effective Jan. 1, 1962. The Reference Committee asked the board to consider an increase in the annual dues of $20 to be implemented over a period of two years: $10 on Jan. 1, 1962, and $10 additional on Jan. 1, 1963.

The House suggested that these funds be used to inaugurate or expand a number of programs including:

1. Financial assistance to medical students.
2. Continuing education for practicing physicians.
3. Health advice to the lay public.
4. Medical research.
5. The expansion by the Communications Division of its program of faithfully portraying the image of the American Medical Association.

It is important, the House emphasized, that the Board of Trustees report recommending a dues increase be transmitted in essence to the grass roots level. *Report on Actions of the House of Delegates AMA Meeting. AMA News. Dec. 12, 1960.*

D. O. Dues

Annual dues of the Ohio Osteopathic Association of Physicians and Surgeons have been raised from $100 to $175, the increase to be distributed to the osteopathic colleges through a progress fund.

Just so far

Automation has struck New York City's Roosevelt Hospital. Last month Miss Marianne Hartmann, a 25 year old nurse, sat down at the new desk that was rigged with a console containing a series of panels, lighted dials, switches, and plug-in sockets. It looked like the cockpit of an airplane.

At any rate, when Marianne turns on the machine she can instantaneously take the temperature of 17 patients located in four special care wards. By using other plug-in sockets she can measure their heart rate and respiration. The EEG and EKG can be read on the same monitor by the attending physician and a permanent record made of incoming information.

This is progress, and we're all for it until some genius devises a robot to take the place of Marianne.

Stomachs shouldn't be waist baskets.—Thomajan

ANNOUNCEMENTS



Clinical Conference

The Annual Clinical Conference of the Chicago Medical Society will be held February 28 through March 3 at the Palmer House, Chicago. The program schedule is as follows:

February 28

Dr. (Ing.) W. B. Kouwenhoven, John Hopkins University, Baltimore, "Closed Chest Resuscitation of Cardiac Arrest."

Dr. George E. Burch, Tulane University School of Medicine, "Physiology of Cardiac Heart Failure."

Dr. Louis Leiter, Columbia University, "Therapy of Heart Failure."

Dr. Robert B. Jennings, Northwestern University Medical School, "The Reaction of the Myocardium to Acute Ischemia."

Dr. Willem J. Kolff, Cleveland Clinic, "Experiments with Artificial Circulatory Devices."

Dr. Maurice Lev, Northwestern University Medical School and University of Chicago, and Ursula F. Rowlatt, D.M., University of Illinois College of Medicine, "Observations on Congenital Heart Disease before and after Surgery (Correlating Clinical and Pathological)."

Dr. C. Walton Lillehei, University of Minnesota Medical School, Minneapolis, "Types of Congenital Heart Disease That Are Amenable to Surgical Correction."

Dr. Robert A. Miller, Northwestern University Medical School, "Cardiac Impairments of Childhood."

Dr. Herman K. Hellerstein, Western Reserve University School of Medicine, Cleveland, "Rehabilitation of Cardiac Patients."

Dr. Howard C. Hopps, University of Texas, Galveston, Moderator, "Clinicopathologic Conference."

March 1

Dr. Howard C. Hopps, "Hypersensitivity Diseases — Causes and Effects."

Dr. Nicholson J. Eastman, emeritus, Johns Hopkins University School of Medicine, Baltimore, "Medical and Surgical Management of Threatened Abortion."

Dr. John Rock, emeritus, Harvard Medical School, Boston, "Clinical Value of Oral Progestins."

Dr. S. Leon Israel, University of Pennsylvania, Philadelphia, "Amenorrhea."

Dr. C. Bernard Brack, Johns Hopkins University School of Medicine, Baltimore, "Urological Diseases in the Female."

Dr. David A. Dreiling, Albert Einstein Medical School, New York, "Physiology and Pathogenesis of Pancreatitis."

Dr. Edwin H. Ellison, Marquette University School of Medicine, Milwaukee, "Surgical Management of Pancreatitis."

Dr. Julian M. Ruffin, Duke University Medical Center, Durham, N. C., "Medical Management of Pancreatitis."

Drs. David A. Dreiling, New York; Edwin H. Ellison, Milwaukee; Julian M. Ruffin, Durham, N. C., "Panel on Pancreatic Disease."

There will be an informal dinner at 7:00 p.m. following the fellowship hour at 6:00 p.m.

March 2

Dr. Roy G. Holly, University of Nebraska College of Medicine, Omaha, "Anemias of Pregnancy."

Dr. Robert A. Kimbrough, Jr., Chicago, "Toxemias of Pregnancy."

Dr. C. H. Hardin Branch, University of Utah College of Medicine, Salt Lake City, "Headshrinking, Couch Sores, and Psychotherapy."

Dr. E. Richard Harrell, University of Michigan Medical Center, Ann Arbor, "Dermatological

Problems Commonly Encountered by the General Practitioner."

Dr. William B. Clark, Tulane University School of Medicine, New Orleans, "Common Eye Problems."

"Auto-Immune Mechanisms in the Production of Renal Disease," to be announced.

Dr. Hans Popper, Columbia University, "Auto-Immune Mechanisms as Related to Cirrhosis of the Liver."

Dr. Peter H. Wright, Northwestern University Medical School, "Antibodies to Insulin."

Dr. Ernest Witebsky, University of Buffalo School of Medicine, Buffalo, "Antibodies in the Production of Thyroiditis."

Dr. Hans Popper, Moderator; Drs. Peter H. Wright and Ernest Witebsky, participants, panel on, "Auto-Immune Mechanisms."

March 3

Dr. Stanley O. Hoerr, Cleveland Clinic, Cleveland, "Surgery of the Common Duct."

Dr. Harold A. Zintel, Columbia University College of Physicians and Surgeons, New York, "Metabolic Problems Associated with Surgical Procedure."

Dr. Donald W. Seldin, University of Texas, Southwestern Medical School, Dallas, "The Syndrome of Potassium Deficiency."

Dr. Bernard J. Michela, Northwestern University Medical School, "Rehabilitation of the Hemaplegic."

Dr. Robert H. Barter, The George Washington University School of Medicine, Washington, D.C., "Surgical Complications of Pregnancy."

There will be film lectures and medical color television each day.

On March 1 there also will be a Clinical Program on Trauma, "What is New in the Care of the Injured Patient?," sponsored by the Chicago Committee on Trauma of the American College of Surgeons.

The schedule is as follows:

Dr. Sam W. Banks presiding.

Dr. John L. Bell, "The Management of Burns."

Dr. Hampar Kelikian, "Skin Defects of the Lower Extremity Due to Compound Injuries."

Dr. Carlo S. Scuderi, "Treatment of Fractures and Fracture Dislocations of the Cervical Spine."

Dr. Burton C. Kilbourne, "Fractures and Dislocations of the Hand."

Dr. James K. Stack, "Current Management of Fractures and Fracture Dislocations of the Carpal Bones."

Dr. Eric Oldberg, "Treatment of Acute Head Injuries."

Dr. John J. Fahey, presiding.

Dr. Vincent J. O'Conor, "Etiology, Diagnosis and Treatment of Bladder and Urethral Injuries."

Dr. James J. Callahan, "Supracondylar Fractures of the Humerus."

Dr. Theodore R. Hudson, "Do's and Don'ts in Acute Chest Injuries."

Panel — Dr. Harold A. Sofield, moderator; Dr. Robert D. Moore, Chicago; Dr. Donald S. Miller, Chicago; Dr. Lyman Smith, Chicago; and Dr. William J. Schnute, Chicago, "Fractures in Children."

Four instruction courses, each running all four days, are also planned. They will be on "Problems in Surgery," "Problems in Medicine," "Problems in Obstetrics and Gynecology," and "Problems in Pediatrics."

Registration fee is $10. An additional charge of $10 will be made for each of the instructional courses. For information write the Society at 86 E. Randolph St., Chicago 1.

Allergists congress

The American College of Allergists Graduate Instructional Course and Annual Congress will be held March 12-17 at the Statler Hilton, Dallas, Texas. For information address John D. Gillaspie, M.D., 2141 14th St., Boulder, Colo.

Blue Shield services increased

Two new Blue Shield programs, each providing an increased schedule of payments to physicians, are now being offered by the Blue Shield Plan of Illinois Medical Service.

The two new certificates, H-300 and I-450, are being offered to meet requests from both physicians and subscribers for expanded protection. At the same time they incorporate many improvements suggested at conferences with various physicians' specialty groups.

Under the H-300 Blue Shield Plan, benefits are provided for surgery wherever performed; allowances for certain operations are increased to a maximum of $300; and the dollar limit for surgical benefits in a 90-day period is removed. Allowances for physician's in-hospital visits are

increased; the maximum benefit period is extended from 70 to 120 daily visits per accident or illness. Special benefits are provided for intensive in-hospital medical care for 25 named conditions. Allowances are also increased for obstetrical care, anesthesia services, and diagnostic x-ray and pathology services. Radiation therapy allowances also are increased, and benefits are provided for the use of radioisotopes in the treatment of hyperthyroidism, chronic angina pectoris, and chronic cardiac decompensation.

The I-450 Blue Shield Plan is a still broader benefit plan with top surgical allowances as high as $450 for certain operations, as well as other increased benefits.

The new programs were developed to meet the need for more intensive care and to help members pay more of the total bill for illness.

Tuberculosis in children symposium

The Chicago Pediatric Society will hold its regular monthly meeting in the Auditorium of the Nurses' Home of Children's Memorial Hospital February 21 at 8:00 p.m.

The program will be a symposium on "Tuberculosis in Children," with Dr. Eugene T. McEnery as moderator. Speakers, all by invitation, are as follows:

Why Should the Private Medical Practitioner Do a Tuberculin Test? Dr. William R. Barclay, associate professor of medicine, University of Chicago.

Prophylaxis of Tuberculosis in Children, Dr. M. R. Lichtenstein, medical director, Municipal Tuberculosis Sanitarium.

Discussants:

Dr. E. A. Piszcek, field director, The Suburban Cook County Tuberculosis Sanitarium District.

Dr. Irving Abrams, director, Bureau of Health Services, Chicago Public Schools.

Questions from the floor will be welcomed.

Michigan Clinical Institute

This annual refresher course will be given in Detroit March 8-10 at the Sheraton-Cadillac Hotel. The program for the first day will deal with surgery in the morning and trauma in the afternoon, and on March 9 with heart and rheumatic fever in the morning and internal medicine in the afternoon. Obstetrics and gynecology will be under discussion on the morning of March 10 and will be followed by the two-hour TV teaching program.

Joint support for research in the Americas

The Pan American Health Organization and the U. S. Public Health Service have agreed to aid in the administration of medical research activities in the countries of the Americas.

The PAHO will provide moderate financial support to certain research projects and programs, conduct research by its own staff, provide coordination for research projects involving more than one country, and aid in the development of scientists, scientific communication, and other medical research activities.

The PHS will provide technical advice on research design. In addition, it will consider research grant proposals from investigators who may wish to participate in research programs coordinated by the PAHO and applications for support to PAHO for research conducted or coordinated by that staff.

American College of Surgeons PG course

The fifth Post-Graduate Course on Fractures and Other Trauma, sponsored by the Chicago Committee on Trauma of the American College of Surgeons, will be held April 19—22, at the John B. Murphy Memorial Auditorium, 50 E. Erie St., Chicago.

The course is dedicated to Dr. Edwin Ryerson, an eminent orthopedic surgeon, a leader in his field and for many years actively associated with the Committee on Trauma.

The course will be presented by a faculty of eleven guest speakers and teachers from the five medical schools and chiefs of services from leading Chicago hospitals who will discuss all phases of trauma.

There will be panel discussions on athletic injuries and fractures and dislocations of the tarsal bones. Many types of fractures and dislocations will be discussed. In addition, there will be audio-visual programs, consultation periods, panel discussions, question and answer periods. Eight

presentations on various types of trauma are scheduled for Friday evening, April 21, from 8:00-10:00 p.m.

Visiting speakers will be Drs. William H. Bickel, Rochester, Minn.; Bruce J. Brewer and Owen E. Miller, Milwaukee; James Barrett Brown, St. Louis; Edwin F. Cave, Boston; C. Howard Hatcher, Palo Alto; Charles C. Higgins, Cleveland; J. William Littler, New York; Austin T. Moore, Columbia, S. C.; Don H. O'Donoghue, Oklahoma City; and Robert A. Robinson, Baltimore.

The registration fee will be $75. Inquiries should be addressed to Dr. John J. Fahey, chairman, 1791 W. Howard St., Chicago 26.

Mayo Clinical Reviews April 10-12

The staff of the Mayo Clinic and faculty of the Mayo Foundation for Medical Education and Research will present again this year a three-day program of lectures and discussions on problems of current interest in general medicine and surgery. There are no fees for this program.

The American Academy of General Practice will give up to 21 hours of Category I credit.

Those wishing to attend should communicate with the Clinical Reviews Committee, Mayo Clinic, Rochester, Minn.; the number of physicians who can be accommodated is necessarily limited.

PG course in arterial vascular disease

The Frank E. Bunts Educational Institute affiliated with the Cleveland Clinic Foundation is offering a postgraduate course in recent advances in arterial vascular disease March 1 and 2.

Guest speakers will be Drs. Ray W. Gifford, and Clark H. Millikan, Rochester; and Ormond C. Julian, Chicago.

Registration will be limited to 125. For further information address the institute at 2020 E. 93rd St., Cleveland 6.

Alcohol studies

The Yale University Summer School of Alcohol Studies will take up the interdisciplinary study of problems of alcohol and alcoholism in society at its annual session June 25 to July 20. There will be lectures, workshops, and seminars. Enrollment is limited to 300 students.

For information concerning admission and credit address The Registrar, Yale Summer School of Alcohol Studies, 52 Hillhouse Ave., Yale Station, New Haven, Conn.

Postgraduate course in Chicago

The department of otolaryngology, University of Illinois College of Medicine, will conduct a postgraduate course in laryngology and bronchoesophagology March 13 through March 25, under the direction of Dr. Paul H. Holinger, Chicago.

Registration will be limited to 15 physicians. The course includes demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, and didactic lectures.

Interested registrants should write directly to the department at the university, 1853 W. Polk St., Chicago 12.

ACS sectional meeting

The annual four-day sectional meeting of the American College of Surgeons will be held in Philadelphia, March 6 through 9 at the Bellevue Stratford, Ben Franklin, and Sylvania hotels.

The program will include hospital clinics, panel discussions, symposia, scientific papers, industrial exhibits, and medical motion pictures in general surgery sessions and in the specialties of obstetrics and gynecology, ophthalmology, otolaryngology, urology, orthopedic surgery, plastic surgery, pediatric surgery, and thoracic surgery.

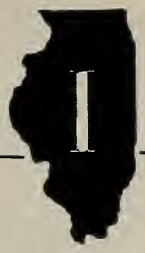
"How I Do It" clinics, educational demonstrations by surgeons noted for specific techniques, will be presented each morning.

Dr. Jonathan E. Rhoads, professor of surgery, University of Pennsylvania Medical School, is chairman of the Local Advisory Committee on Arrangements.

Correction

The trade name for 30 per cent urea is Urevert, not Uretrit as it appeared in "Trends in the Care of Glaucoma" by Max Hirschfelder, M.D., published in the December Journal, page 352.

NEWS of the STATE



County

Champaign

Dr. Stuart Roberts, University of Illinois, spoke to the Champaign County Medical Society February 9 in Champaign on "Spread of Tumor Cells During Surgery."

This lecture was arranged by the Committee on Postgraduate Medical Education and Scientific Service of the Illinois State Medical Society.

Cook

Northwestern Grants. Northwestern University Medical School was awarded grants in December totaling more than $127,000 from U.S. Public Health Service for research and fellowships.

Recipients were Dr. David P. Earle, professor of medicine, $33,090 for the study of abnormal physiology in influenza and other infections; Dr. James A. Lippincott, assistant professor of biological sciences on the Evanston campus, $34,308 for study on the effects of nucleic acids on plant tissues; Dr. Morton S. Rosen, assistant professor of the cleft palate institute, for research on nasality as it relates to the way throat and palate muscles close during speech; and Dr. Edward L. Compere, professor of orthopedic surgery, for research on transplantation of artery to bone.

Other recipients were Dr. Paul Kezdi, assistant professor of medicine, for research on transient nerve block in enlarged hearts; Dr. Virgil Koenig, associate professor of neurology and psychiatry, for research in fractionation of proteins in the lens of the eye; and Dr. Wendell J. Krieg, professor of anatomy, for research on nerve connections in monkey brains.

In January the medical school received $551,202 in grants from the U.S. Public Health Service for advance training in the medical and biological sciences. The awards are in the form of training grants, research fellowships, and traineeships in the fields of allergy, arthritis, cancer, diabetes, heart diseases, mental health and neurological diseases.

Recipients are as follows: Dr. Benjamin Boshes, chairman and professor of neurology and psychiatry; Dr. Arthur R. Colwell, chairman and professor of medicine; Dr. Gene Stollerman, associate professor of medicine; Dr. George K. Yacorzynski, professor of neurology and psychiatry; Dr. Irving Schulman, professor of pediatrics; Dr. R. I. Watron, lecturer in neurology and psychiatry; Dr. G. W. Allen, associate in otolaryngology; Dr. William B. Wartman, professor and chairman of pathology; Dr. David Earle, professor of medicine; Dr. C. A. Dragstedt, professor of pharmacology; Dr. J. S. Gray, professor of physiology; and Dr. E. Clinton Texter, assistant professor of gastroenterology.

A Change in Format. It has been announced that the North Shore Hospital for the care and treatment of emotional disorders, Winnetka, has been operating on an open staff format since January 1.

Qualified psychiatrists interested in joining the hospital's staff should write to Dr. Milton A. Dushkin, Medical Director, for application forms.

Northwestern Tops in Training Physicians. Northwestern University Medical School ranks first of all U.S. medical schools in the number of physicians graduated who go into medical practice, according to a report in a recent issue of the Journal of Medical Education. It also ranks third in supplying physicians who go into full time medical college teaching or research. These statistics were based on a survey of present professional activities of 1950 graduates of all American medical colleges. The study

was made by the Council on Medical Education and Hospitals of the American Medical Association and by the U.S. Public Health Service under the direction of Dr. Herman G. Weiskotten, dean emeritus of Syracuse Medical School.

The survey has been carried out at ten-year intervals. Northwestern has been among the top five medical schools since 1915 in graduates who continued their training and went into a specialty. It ranks in the top ten in the country and leads in the Chicago area in the number of graduates who have gone into teaching and research since 1935.

The survey also showed that most of Northwestern's graduates who went into full time teaching and research were not trained solely for school, but joined the staffs of colleges all over the country.

The survey was made to help medical educators learn more about the various capacities in which medical college graduates serve the public in the maintenance of health and the treatment of disease. Authors of the report were Herman G. Weiskotten, M.D., Walter S. Wiggins, M.D., Marion E. Altenderfer, Marjorie Gooch, Sc.D., and Anne Tipner.

Growth of Medicine Lectures. This series of lectures is being given by Northwestern University from January through March, 1961, from 8 to 9 a.m. in the Ward Building, Room 641. The programs through February were published in the December Journal. The final portion of the series is as follows:

Mar. 1—"Resurrection Men," Leslie B. Arey, Ph.D., professor of anatomy, emeritus, at the university.

Mar. 8—"Contributions of Africans and Their American Descendents to Modern Medicine," Leonidas Berry, M.D., clinical assistant professor of medicine, University of Illinois College of Medicine.

Mar. 15—"The Story of Heart Surgery," Willis J. Potts, M.D., professor of surgery, Northwestern University Medical School.

Appointments. Dr. Cecil S. Cummins, British bacteriologist, has been named visiting "investigator" at Northwestern University Medical School. Dr. Cummins' work in the microbiology department will center on investigation of the internal structure and biological activity of streptococci bacteria. This research is related to Northwestern's long-range program of series of upper respiratory system diseases and rheumatic fever, both involved with the streptococci.

Dr. George Pollock has been appointed assistant dean of the Institute for Psychoanalysis of Chicago.

Research Grants. The Chicago Board of Health has been granted $10,500 by the Wesson Fund for Medical Research and Education. The funds are for research headed by Dr. Jeremiah Stamler on improvement of procedure for making nutritional assessments and recommendations in connection with the board's coronary prevention and evaluation program.

Forest Hospital Scientific Program. The third annual Scientific Program at Forest Hospital, Des Plaines, begun on October 26, 1960, will continue through June, 1961. The program through February 22 was given in the December Journal. The remainder of the schedule is as follows:

Mar. 22—"The Space Child—Ten Years Later," Rudolf Ekstein, Ph.D., Reiss-David Clinic for Child Guidance.

April 26—"New Trends in Direct Analysis," John N. Rosen, M.D., Temple University.

May 24—"The Origin and Development of Schizophrenia in the Family Name," Murray Bowen, M.D., Georgetown University.

June 28—"Sexual Processes in Schizophrenia," Harold F. Searles, M.D., Chestnut Lodge, Rockville, Md.

Elected. Dr. Jack Allan Weiss has been elected chairman of the ear, nose, and throat department of Cook County Hospital.

Branch Society meetings. Dr. Henry T. Ricketts, professor of medicine, University of Chicago Medical School, spoke at the February 7 meeting of the Englewood Branch of the Chicago Medical Society at Englewood Hospital. His subject was "Oral Hypoglycemic Agents."

Dr. Paul R. Rosenbluth, clinical instructor of neurology and neurosurgery, University of Illinois College of Medicine, will talk to the Branch May 6 at 9:15 p.m. at the Central Community Hospital. He will speak on "Improve-

ments in the Diagnosis and Treatment of Intracranial Vascular Accidents."

These lectures were arranged by the Committee on Postgraduate Medical Education and Scientifie Service of the Illinois State Medieal Society, Dr. Louis R. Limarzi, chairman.

Rehabilitation Institute administrator. John B. Perkins, New York, is the new administrator of the Rehabilitation Institute of Chicago. The newly created position is expected to strengthen the business management, personnel, public relations, and fund raising activities of the institute, and enable the director, Dr. Bernard J. Michela, to devote more time to medical and professional phases of the program at the Rehabilitation Institute.



John B. Perkins

Perkins attended Northwestern University and is a senior member of the American Association of Hospital Accountants. He was treasurer-business manager of the Christian Herald Association, Inc. and has worked in clinic management and hospital administration in Chicago.

Honored. Dr. Lowell T. Coggeshall, vice president in charge of medical affairs at the University of Chicago, recently received a Distinguished Achievement Award from *Modern Medicine* for service as an administrator and medical statesman and for achievements in tropical medicine.

He is one of 10 nominated by deans of medical schools, leaders of professional medical organizations, and readers, selected by the magazine for contributions directly influencing medical progress in the United States.

Dr. Coggeshall has been dean of the University of Chicago's division of biological sciences for 13 years, heading the teaching, research, and clinical facilities of the medical school, six affiliated hospitals, and the department of biological sciences. He was special assistant for health and medical affairs to the secretary of the Department of Health, Education, and Welfare during 1956-57 and is at present on the executive board of the World Health Organization, after serving as chairman of the Defense Department's Committee on Medical Research and Development.

Sangamon

Dr. William R. Best, assistant professor of medicine, University of Illinois Medical School, spoke to the Sangamon County Medical Society in Springfield February 2 on the subject "Baffling Anemias."

Vermilion

The Vermilion County Medical Society at its December 6 meeting elected its officers for 1961. They are Dr. A. J. Rarick, president; Dr. E. T. Baumgart, vice-president; Dr. L. W. Tanner, secretary-treasurer; Dr. J. W. Moore, delegate to the Illinois State Medical Society; and Dr. D. D. Spicer, alternate delegate.

The formation of the scholarship fund for medical schools to be established by the AMA was also mentioned at the meeting.

White

The White County chapter of the March of Dimes planned a "Pigs Against Polio" campaign to give rural people a better opportunity to contribute. The chapter appointed "Operation Pork Chop" committees throughout the country to contact farmers and ask them to donate one market-size hog to the New March of Dimes.

Whiteside

Dr. Walter C. Bornemeier, Northwestern University, spoke at the Whiteside County Medical Society's meeting in Sterling January 19 on "Soeial Security for M.D.'s."

The lecture was arranged by the Committee on Postgraduate Medical Education and Scientific Service of the Illinois State Medical Society.

General

University of Illinois class reunions

Members of the University of Illinois College of Medicine classes of 1911 and 1936 will be given special recognition at the Medical Alumni

Annual Banquet May 15. The association is reinstating a policy of awarding gold certificates to men celebrating their fiftieth reunion, and is initiating a policy of awarding silver certificates to men having their twenty-fifth reunion.

These certificates will be presented at the banquet to alumni from these two classes. Other classes scheduled for reunions are those of 1906, '16, '21, '26, '31, '41, '46, '51, and '56.

Anyone interested in a reunion of his class should contact the Alumni Office, University of Illinois College of Medicine, 1853 W. Polk St., Chicago 12 to make arrangements.

1960 hospital construction

Sixteen applications for construction of hospitals and related facilities in Illinois were approved by the state in 1960 for grant-in-aid assistance under provisions of the Illinois Hospital Survey and Construction program. Funds totaling $5,953,951 have been committed to these projects.

Ten were for new general hospitals or additions to existing ones. They are located in Nashville, Chester, Hoopeston, Skokie, Streator, Joliet (St. Joseph's Hospital), Savanna, Galena, Naperville, and Rockford (St. Anthony's Hospital), providing a total of 1,138 beds.

Six special category projects also approved were one chronic illness unit (Chicago), with 34 beds; two diagnostic and treatment centers (Chicago); three skilled nursing homes (Metropolis, Belleville, and Ottawa), providing a total of 152 beds.

Virtually all hospitals in Illinois are under its licensing-inspection. About 300 general and special hospitals were licensed in 1960.

Crippled children's clinics

March clinics arranged by the University of Illinois, Division of Services for Crippled Children, are as follows:

March 1 Carmi, Carmi Township Hospital
March 1 Hinsdale, Hinsdale Sanitarium
March 2 Effingham, St. Anthony Memorial Hospital
March 3 Chicago Heights (Cardiac), St. James Hospital
March 8 Champaign-Urbana, McKinley Hospital
March 8 Joliet, Silver Cross Hospital
March 9 Springfield, St. John's Hospital
March 9 Sterling, Community General Hospital
March 14 East St. Louis, St. Mary's Hospital
March 14 Peoria, Children's Hospital (a.m. - Cerebral Palsy) (p.m. - General)
March 15 Evergreen Park, Little Company of Mary Hospital
March 15 Jacksonville, Passavant Hospital
March 16 Elmhurst Cardiac, Memorial Hospital of DuPage County
March 16 Decatur, Decatur-Macon County Hospital
March 16 Rockford, St. Anthony's Hospital
March 16 Sparta, Sparta Community Hospital
March 21 Alton, Alton Memorial Hospital
March 22 Aurora, Copley Memorial Hospital
March 22 Centralia, St. Mary's Hospital
March 22 Springfield (p.m. - Cerebral Palsy), Memorial Hospital
March 23 Effingham (Rheumatic Fever), St. Anthony Memorial Hospital
March 28 Peoria, Children's Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective, and other services and facilities for diagnosis, hospitalization, and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling.

Foundation chapter elects officers

Dr. Evan M. Barton, clinical associate professor of medicine, University of Illinois College of Medicine, has been re-elected for a second term as chairman of the Medical and Scientific Committee of the Illinois Chapter of the Arthritis and Rheumatism Foundation.

Elected for a one year term as vice-chairman of the Committee was Dr. Stanley Fahlstrom, associate clinical professor of medicine, Stritch School of Medicine, Loyola University.

Begin work on state museum

Ground-breaking ceremonies were held January 5 for the new $1.8 million Illinois State Museum building to be completed by 1963. With this new scientific and educational institution

Illinois will be one of 15 states having special accommodations for their museums. Bids submitted by contractors were three-quarters of a million dollars under the estimated cost.

The museum, begun 84 years ago as a small geological collection, has 2 million visitors per year.

Dr. Bettag Mental Retardation Board appointee

Dr. Otto L. Bettag, state welfare director for eight years, has been appointed to the new 14-member Advisory Board on Mental Retardation of the Illinois Department of Public Welfare. He was chosen for a two-year term as a civilian member for the wisdom and experience he has accumulated in the medical and administrative areas of public health and public welfare.

Eight members were appointed for 2-year terms: one member of each major party from the House and the Senate and four members from the general public. Six members from agencies dealing with mental retardation and related problems were appointed for one year.

The board will study all problems and programs relating to mental retardation and make regular reports and recommendations for legislation and administrative changes to the Director of the Department of Public Welfare and other state agencies and the General Assembly. It will meet at least four times annually, and all members will serve without compensation.

Deaths

Julian Arendt*, Chicago, a graduate of the Universitat Medizenische Fakultat, Breslau, Prussia in 1929, died December 11, aged 62. He was chief of radiology at Mt. Sinai Hospital from 1946 to 1958 and assistant professor of radiology at the Chicago Medical School. A native of Germany, Dr. Ahrendt came to America in 1937 after teaching and practicing in Germany, Switzerland, and Iran. He was a fellow of the American College of Radiology and a diplomate of the American Board of Radiology.

Fred L. Baratta, retired, Ft. Lauderdale, a graduate of the Hahnemann Medical College and Hospital in 1922, died December 19, aged 70. He was a staff member at Woodlawn and Illinois Central hospitals before retiring three years ago.

Guy E. Carlson*, Riverside, a graduate of Rush Medical College in 1925, died January 3, aged 69. He had been on the staff of West Suburban Hospital in Oak Park.

John Sheldon Clark*, retired, Freeport, a graduate Northwestern University Medical School in 1903, died December 10, aged 85. In 1913 he went to Europe for postgraduate work at the University of Vienna. He was a fellow of the American College of Surgeons and the American Academy of Ophthalmology and was a diplomate of the American Board of Laryngology. He was house surgeon at the Illinois Charity Eye and Ear Infirmary before retiring in 1948 and had been on the Freeport school board for many years, serving several times as board president.

John Andrew Cousins*, retired, Arlington Heights, a graduate of the Keokuk Medical College of Physicians and Surgeons, Iowa in 1905, died December 18, aged 81. He had been a member of the staff at Woodlawn Hospital since its founding in 1928 and served as a captain in the Army medical corps in World War I.

Gusta Davidsohn* (see Mittlemann).

George L. Drennan*, Jacksonville, a graduate of Washington University School of Medicine, St. Louis in 1925, died December 13, aged 62. He was past president and past secretary of the Central Illinois Pediatric Society, and a member of the American Academy of Pediatricians and the American Medical Association. He was instrumental in establishing the Well Baby Clinic in Morgan County, now part of the Morgan County Health Department, and for many years had been physician for the Illinois School for the Deaf and the Illinois Braille and Sight-saving Schools at Jacksonville. He was a member of the board of directors for the Elks Club Crippled Children Fund and had practiced in Jacksonville since 1926. He was a naval officer in World War II and retired as a captain.

Edgar W. Killian*, Streator, a graduate of the Stritch School of Medicine of Loyola University in 1944, died January 4, aged 43.

Howard M. Lenn*, Evanston, a graduate of Dalhousie University Faculty of Medicine, Halifax, Nova Scotia in 1926, died December 25, aged 59.

Fred Lee Lingle, Carbondale, a graduate of the St. Louis College of Physicians and Surgeons

in 1904, died August 29, aged 78. He was on the staffs of Doctors and Holden hospitals.

Ausby L. Lowe, Jr.*, Robinson, a graduate of Rush Medical College in 1905, died December 19, aged 80. He had practiced in Robinson since 1908 and helped build and operate the Robinson Hospital until its sale in 1946. He was a major in the medical corps in World War I.

Gusta Davidsohn Mittlemann*, Chicago, a graduate of the University of Vienna in 1930, died December 25, aged 58. She had been director of physical medicine and rehabilitation at Mt. Sinai Hospital since 1941 and was an associate professor of medicine at Chicago Medical School. She was also on the staffs of Rest Haven and Park View Home and a director of the BHZ Old People's Home.

Charles E. Molden*, Troy, a graduate of the St. Louis College of Physicians and Surgeons in 1907, died December 11, aged 85. He was a staff member emeritus of St. Joseph's Hospital in Highland, a member of the 50-Year Club, and a past president of the Madison County Medical Society. He was a member of the Academy of General Practice and was named Troy Citizen of the Year in 1950.

Carl A. Starck*, Palatine, a graduate of the University of Illinois College of Medicine in 1904, died January 2, aged 80. He was on the staffs of St. Joseph's and Sherman hospitals and former head of Palatine's Community Hospital.

Anita Varraveto*, Chicago, a graduate of the University of Illinois College of Medicine in 1940, died December 20, aged 49. She was a staff member at Ravenswood Hospital.

George H. Vernon*, Glen Ellyn, a graduate of the University of Illinois College of Medicine in 1931, died December 12, aged 56. He was killed in an automobile accident. He became medical director of the DuPage County Tuberculosis Clinic in September 1960, and was medical director and superintendent of the Madison County Tuberculosis Sanatorium for seven years before that. He was past president of the Madison County Medical Society and served at the Palmer Tuberculosis Sanatorium in Springfield.

Arshak Y. Yazarian, Oakwood, a graduate of the Chicago Medical School in 1933, died December 3, aged 58. A native of Turkey, he was a federal government physician from 1935 to 1938 in the Pribiloff Islands off Alaska and was in the U.S. Army medical corps as a physician from 1942 to 1946. He had practiced in Oakwood since 1947.

**Indicates member of the Illinois State Medical Society.*

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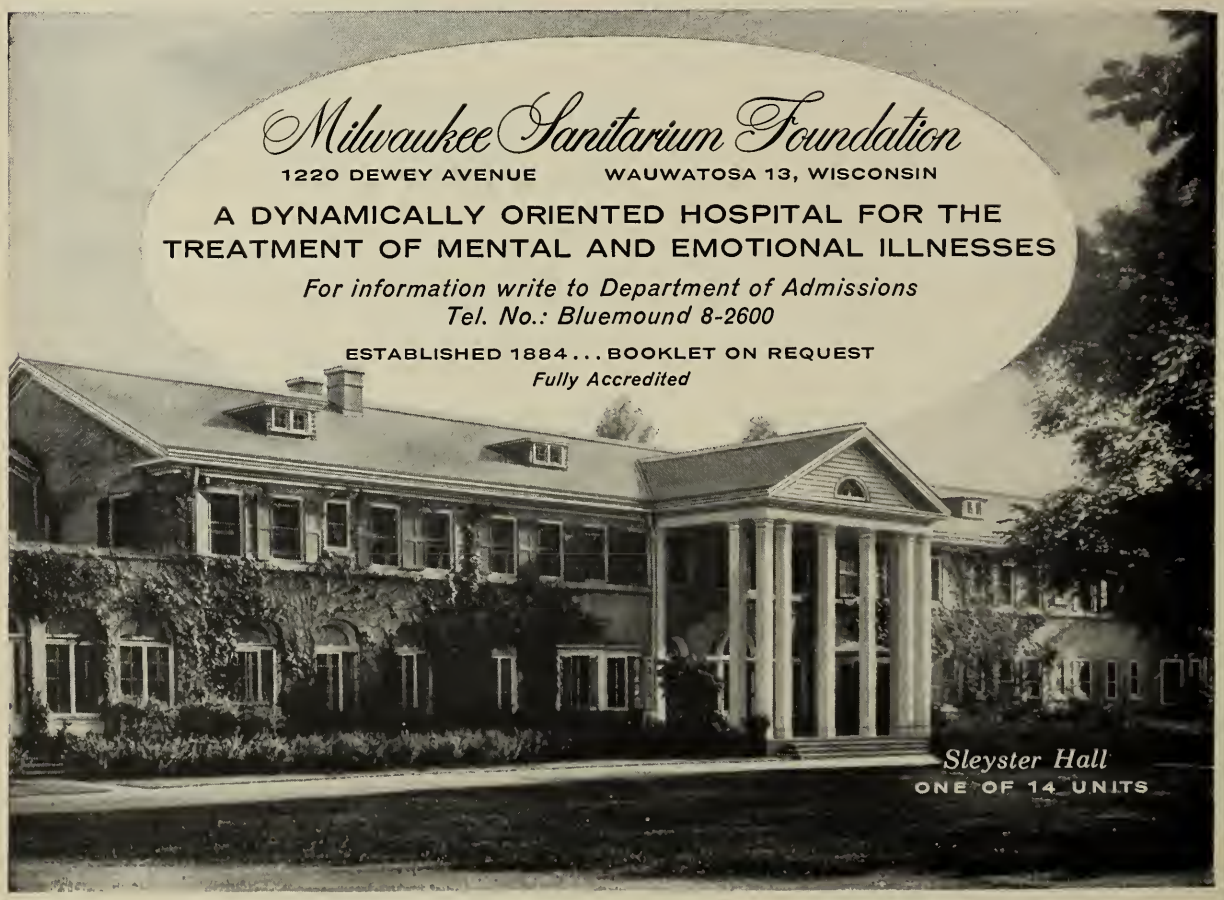
Effects of the aging population

The staggering increase in the number of persons aged 65 and over in this country may explain a considerable part, if not all, of what might seem a paradoxical situation. Despite the generally improving health levels of the population, evidenced in low mortality rates and the decline of the communicable diseases as leading causes of death, there has been an increased prevalence of such symptoms of ill health as chronic illness and various impairments, such as blindness and hospitalized mental illness. Similarly, the rise in the aged population may also explain a considerable part of the increase in the need for and use of personal health services—hospital care and nursing homes, physicians' and dentists' services, drugs and medications, appliances, etc. —as well as of the increase in consumer spending for these services.

On the positive side of the ledger, the increase in survivorship has apparently contributed to a strengthening of family ties in this country. At least, the break-up of marriage by the death of one partner at a young age or during mid-life is far less common than formerly, so that marriages now last much longer, on the average. Widowhood has, on the whole, been largely postponed to much older ages, by which time the responsibility for minor children is generally not great. *Increased Life Expectancy in the U.S. Health Information Foundation. December, 1960.*

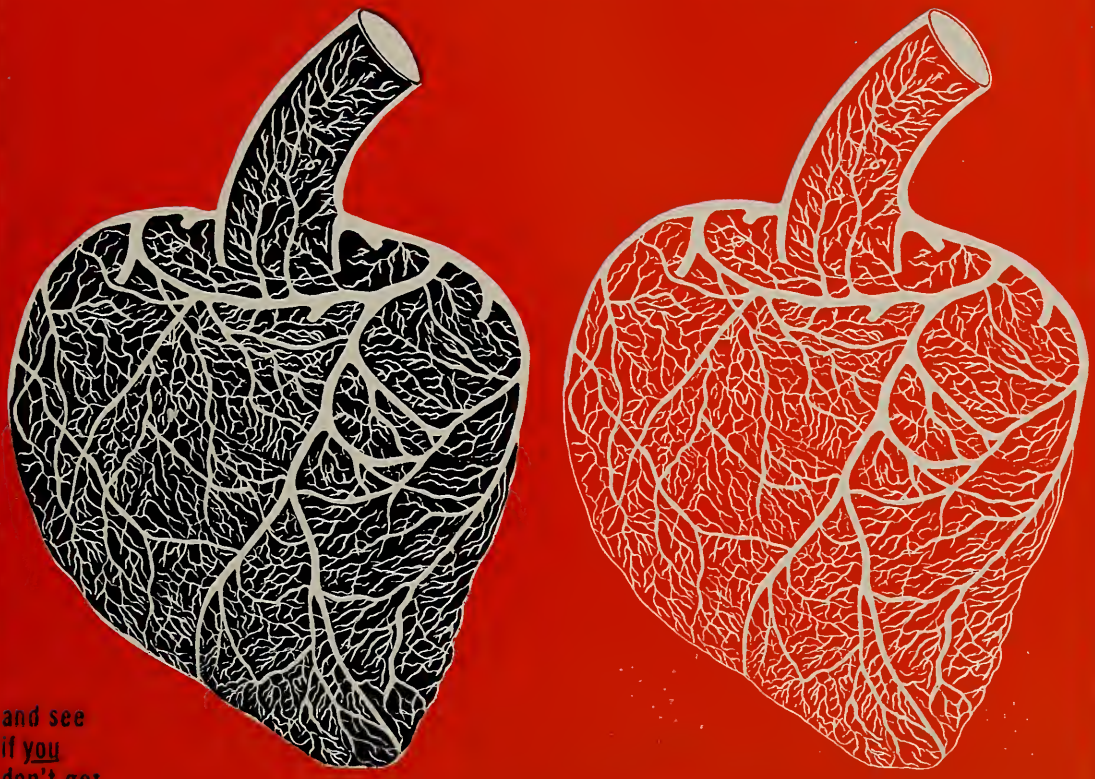
Fish or cut bait

Ophthalmologists cannot ignore contact lenses. They have been developed to the point that they are an important adjunct in the practice of ophthalmology. It is not unusual to find patients wearing the lenses for 8 to 16 hours, with little or no discomfort. Frequently, lay publications, radio, and television relate the great advances made in contact lenses. Regardless of any prejudice ophthalmologists might have, patients wearing glasses with strong corrections do not like the resulting cosmetic defect. If ophthalmologists do not fit them, someone else will. *P. W. Malone, M.D. Fitting Contact Lenses: Practical Points. Texas J. Med. Aug., 1960.*



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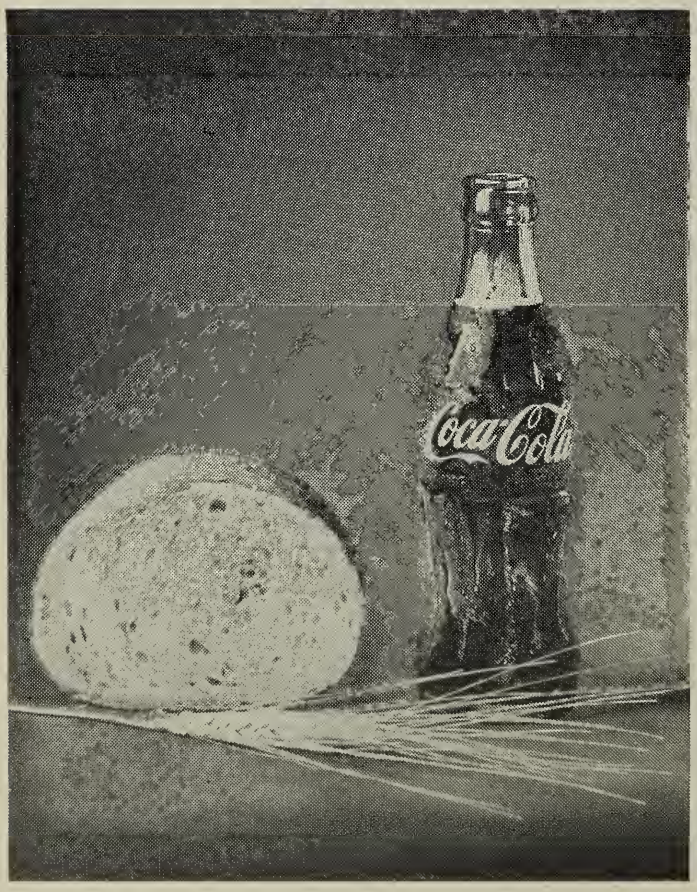
Cecal diverticulosis and diverticulitis is not an uncommon cause of right lower quadrant pain. The point of tenderness is usually over the cecum, but it may be over McBurney's point. Nausea and vomiting are absent, however, which is helpful in differentiating it from acute appendicitis. Diseases of the right adnexa, right ureteral calculus, spastic colon, carcinoma of the cecum, and other disorders with right lower quadrant pain must be considered in the differential diagnosis. Barium enema studies may not reveal the diagnosis if the diverticula arise from the anterior or posterior walls unless an almost lateral projection is made. The treatment is conservative in the absence of surgical emergencies. *Leon Sasson, M.D. Cecal Diverticulitis. Am. J. Gastroen. December, 1960.*

There are two things needed in these days; first, for rich men to find out how poor men live; and, second, for poor men to know how rich men work.

—E. Atkinson



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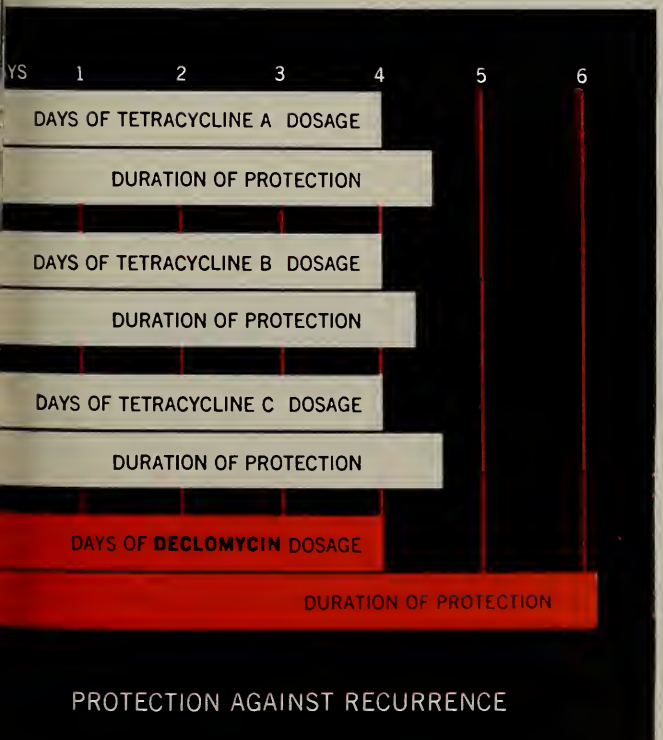
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Errand-running tube system

A pneumatic tube system, with twenty stations on five floors of the main building and portions of three other buildings, has been installed at Huntington Memorial Hospital, Pasadena, Calif. The carriers, which are large enough to take medium sized x-ray films or a package of surgical instruments, are propelled by high-powered air-streams under guidance of electronic controls, and are addressed by setting two rotating rings to the code number of the station required. Insertion into the outgoing tube starts the carrier on its way. As the carrier passes through key points, the code number is read by an electrical sensing unit, and the carrier is deflected into the appropriate branch tube leading to its destination. Most professional and administrative papers are carried by the system. Prescriptions are sent to the pharmacy and non-liquids returned. Neither money nor liquids are transported in this way, but glassware, if well-padded, travels by the tube. Central supply has repacked many articles to fit the carriers. Professional and other staff spend far less time on errands, and the receipt of work in administrative departments is more evenly distributed. All service points must be accessible, and adequate preventive maintenance is necessary to minimize breakdowns. *G. W. Gilbert. They Send It By Tube To Save Time and Traffic. Mod. Hosp. January 1960.*

Cancer virus not contagious

Though viruses may turn out to be important in the causation of human cancer—and many scientists think they are—this does not mean that cancer is contagious in the sense that the common cold is. No evidence at all has been found that cancer is "catching." Perhaps this may be an instance where the disease is caused by an infectious agent, as in appendicitis, but which is not freely communicable by contact. Or it may be that the cancer-causing viruses are so widely distributed that large segments of our people have built up an immunity; or that the viruses are locked in the cells at birth, being transmitted only from mother to child. *Review of Research Accomplished by Scientists Supported by ACS Grants. Am. Cancer Soc. News Service. Fall, 1960.*

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Entered as Second Class Matter Nov. 12, 1952, at the Post Office, Mendota, Illinois, under the Act of March 8, 1879.

Acceptance for mailing at special rate of postage provided for in section 1102, Act of Oct. 8, 1917, authorized July 15, 1918.

POSTMASTER: Send notices on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago 1, Ill.

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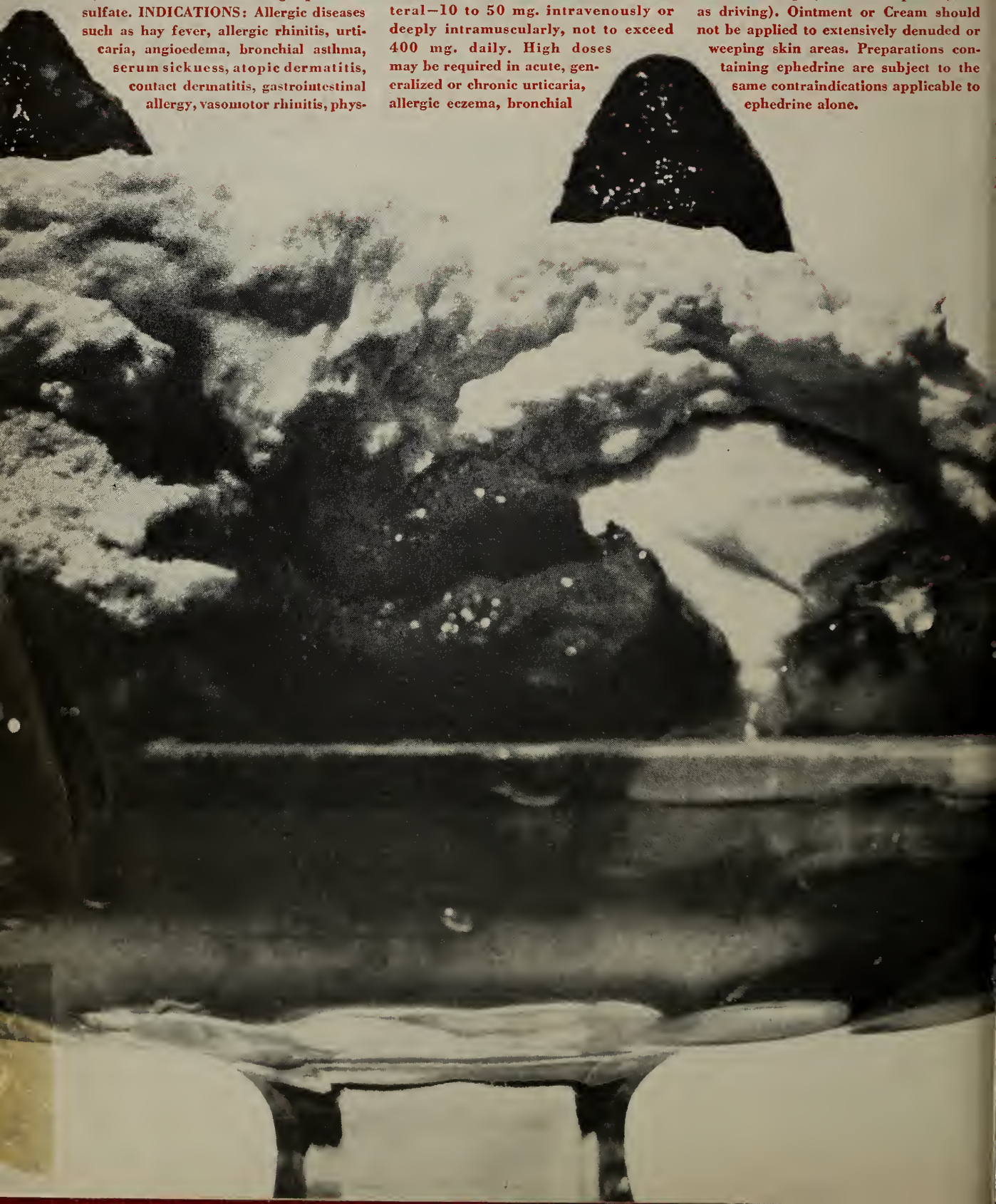
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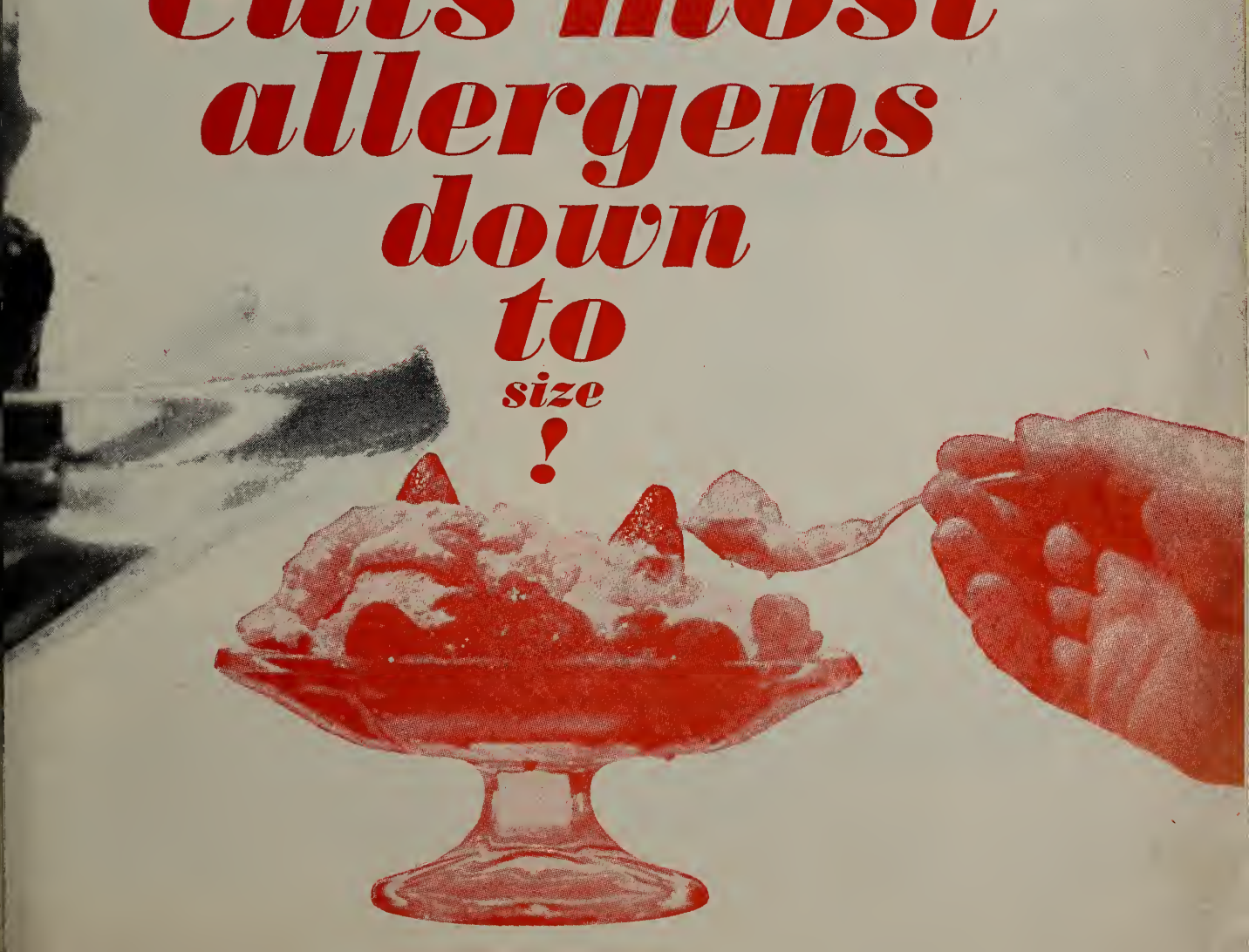
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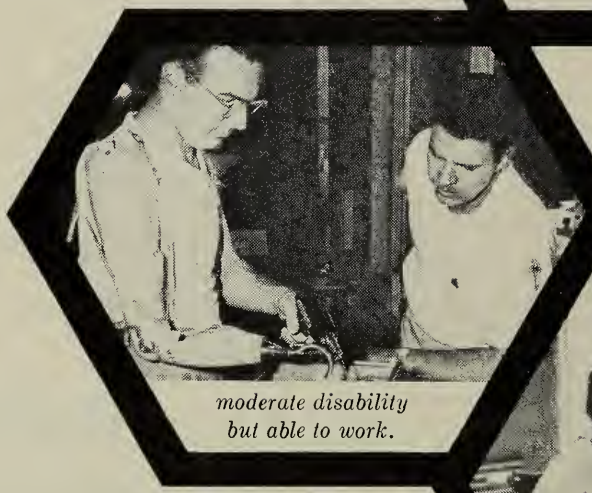
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The Month in Washington



President Kennedy asked Congress to increase social security taxes to finance limited medical care for elderly persons on the social security rolls, a plan opposed by the medical profession. The proposal was part of a sweeping health program outlined by Kennedy in a special message to Congress during his first month in the White House.

The Kennedy program also included federal aid for construction and operation of medical schools, scholarships for medical and dental students, grants for community nursing and hospital services, stepped-up medical research, and expanded federal activity in the field of child and youth health.

Under Kennedy's proposal, social security beneficiaries 65 years and older could get up to 90 days of hospitalization for each single illness. However, the patient would have to pay $10 daily for the first nine days of hospitalization with a minimum payment of $20.

After release from a hospital, the elderly person could get up to 180 days in a nursing home. The social security program also would provide for payment by the government of all out-patient diagnostic costs in excess of $20 and community visiting nurse services.

The program would be financed by increasing social security taxes by one-fourth of one per cent on both employers and workers and by three-eighths of one per cent on self-employed persons covered by social security. The social security tax base also would be increased from the present $4,800 a year to $5,000.

Enactment of this proposal, coupled with another Kennedy recommendation and increases in the social security tax already scheduled in the law, would mean that workers and employers would be paying $250 each in social security taxes in 1969.

Nationwide television audiences were told by an American Medical Association spokesman why the medical profession supports the Kerr-Mills program of medical care for the aged and opposes tieing it in with social security.

In television debates with Sen. Hubert Humphrey (D., Minn.) on NBC-TV and Walter Reuther, organized labor spokesman, on CBS-TV, Dr. Edward R. Annis of Miami, Fla., described the Kerr-Mills program as "sound and effective." He said it "must be given the chance it deserves. Congress passed it because it believed that the important thing was to help the people who need help; to help them quickly; and to help them through the machinery of local government," Dr. Annis said.

The AMA Board of Trustees charged the CBS network with "misrepresentations, bias, and distortions" on another program: "The Business of Health—Medicine, Money and Politics."

The network edited out of the taped program the AMA's true position:

"The AMA believes that any medical care plan

(*Continued on page 22*)

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1. Graham, W.: Canad. M.A.J.: **82**:1005 (May 14) 1960. 2. Vaughn, P. P.; Howell, D. S., and Kiem, I. M.: Arth. and Rheumat. **2**:212, 1959. 3. O'Reilly, T. J.: J. Irish M.A. **46**:106, 1960. 4. Connell, J. F., Jr., and Rousselot, L. M.: Am. J. Surg. **98**:31, 1959. 5. Brodie, B. B., et al., in Contemporary Rheumatology 1956, p. 600. 6. Stein, I. D.: Ann. N. Y. Acad. Sc. **86**:307 (March 30) 1960. 7. Barczyk, W., and Röth, W.: Praxis **49**:589, 1960. 8. Miller, J. M., et al.: Antibiotic Med. and Clin. Therap. **7**:109, 1960. 9. Connell, J. F., Jr., and Rousselot, L. M.: Am. J. Surg. **97**:429, 1959. 10. Summary of individual case histories submitted to Geigy. 11. Domenjoz, R.: Ann. N. Y. Acad. Sc. **86**:263, 1960. 12. Smyth, C. J.: Ann. N. Y. Acad. Sc. **86**:292, 1960.

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WASHINGTON (Continued)

is both unsound and unfair which would compel working people to shoulder increased social security taxes to finance health costs of all those over 65 (under social security), rich and poor alike, regardless of whether they want or need such help and which, at the same time, ignores millions of indigent elderly who do need help."

Kennedy's health program faced strong opposition in Congress. The concensus of Capital Hill observers was that it stood a 50-50 chance of getting Congressional approval but not before it had been cut down. There were some who doubted that the Administration's program for medical care of the aged would be acted upon, at least by both houses of Congress, before next year.

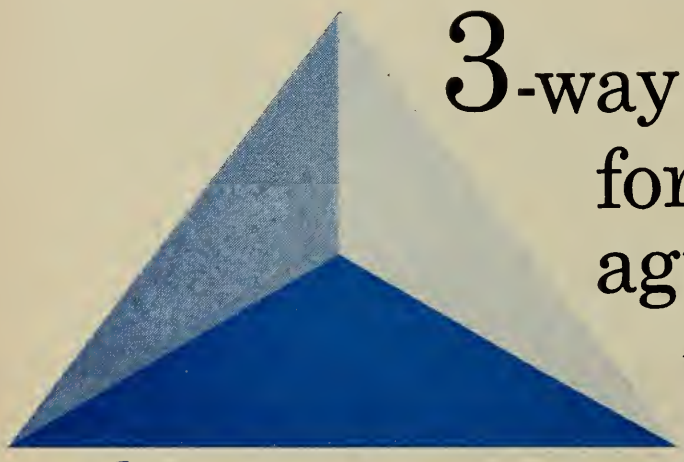
Even some Democratic Congressmen with the liberal label were taken back by the scope of Kennedy's health program.

Arthur H. Motley, president of the Chamber of Commerce of the United States, warned that social security taxes are being increased to a point "where people might rebel against the whole Social Security system."

He contended that this nation's present personal medical care system is the best of any large nation. "It's worth crusading for and that is what the Chamber is doing," Motley said.

A good idea

With the approach of more and more socialization in the practice of medicine, audits of hospital records will become more and more important, for it stands to reason if a third party begins to exercise more authority in the field of health care, medical audits of clinical procedures will become necessary. If a staff then does not audit its own hospital work, a third party will take over the responsibility. And if a staff permits a third party to audit how they practice medicine, they will have no one but themselves to blame when they lose their freedom in the practice of medicine. An Internal Medical Audit Committee in a hospital is an important safeguard to prevent this loss of freedom. *Don W. Branham, M.D. Editorial. The Internal Medical Audit. J. Oklahoma M. A. December 1960.*



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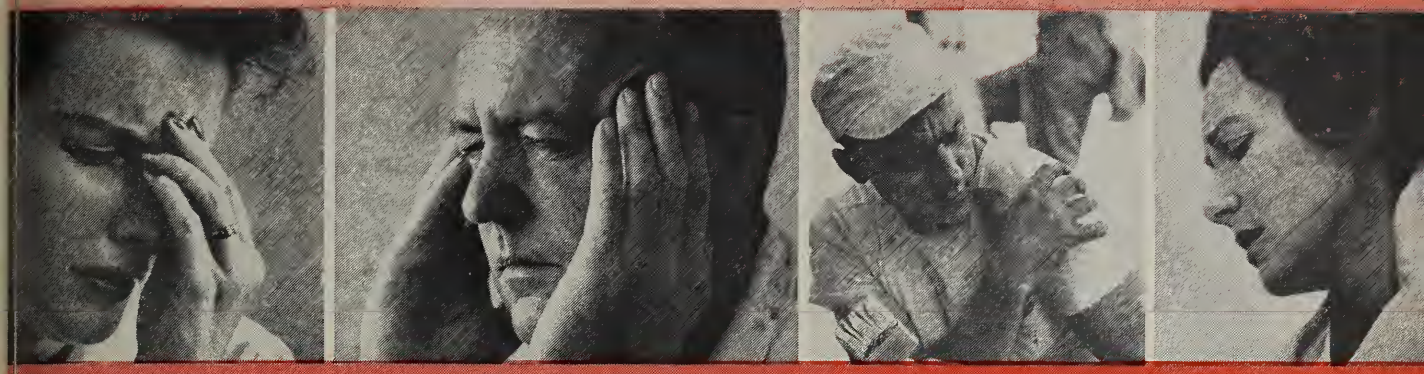
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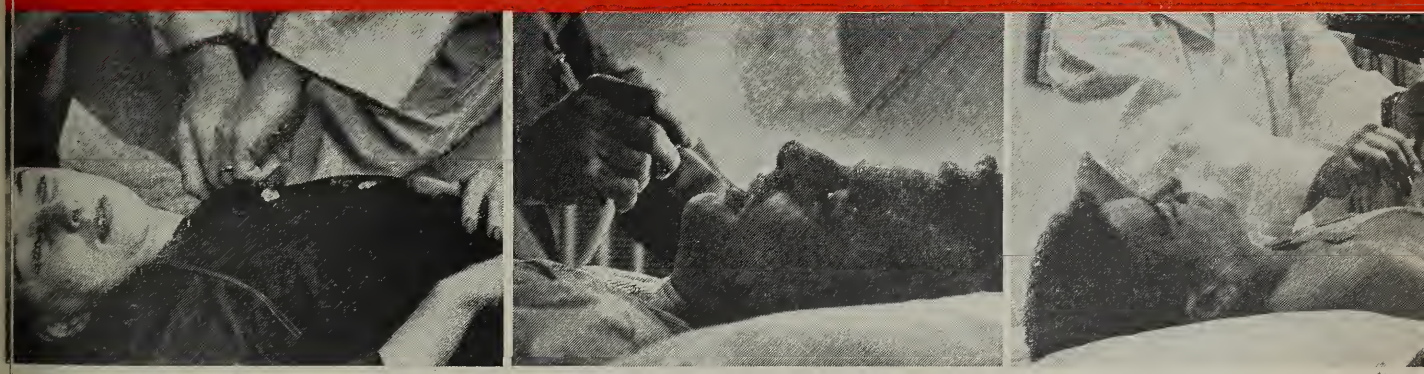
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Experience, now of close to 20 years, has validated this procedure yet at the same time overlooks a paradox whose significance is entirely unclear. When radioactive iodine is given by mouth, the entire dose is of course promptly delivered to the stomach. Here some radiation occurs during the interval before passage into the small intestine and complete absorption into the blood has ocurred. When the iodine is in the blood and circulating, a very considerable fraction reaches the gastric circulation and here it is ex-

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1. Barclay, P. L.: J.A.M.A. 174:474, Oct. 1, 1960.

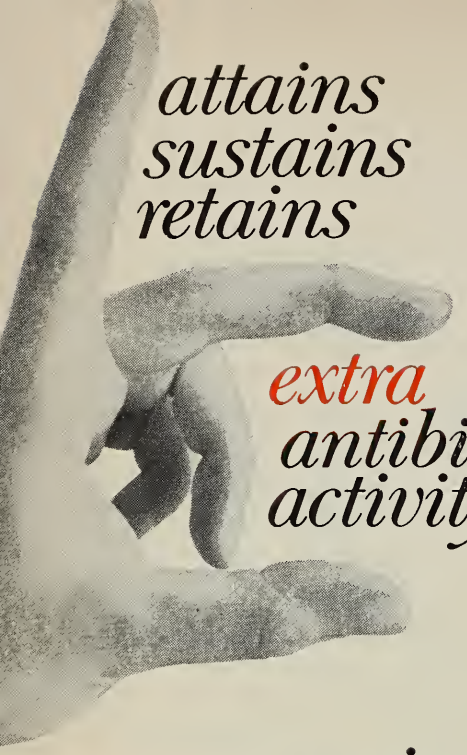
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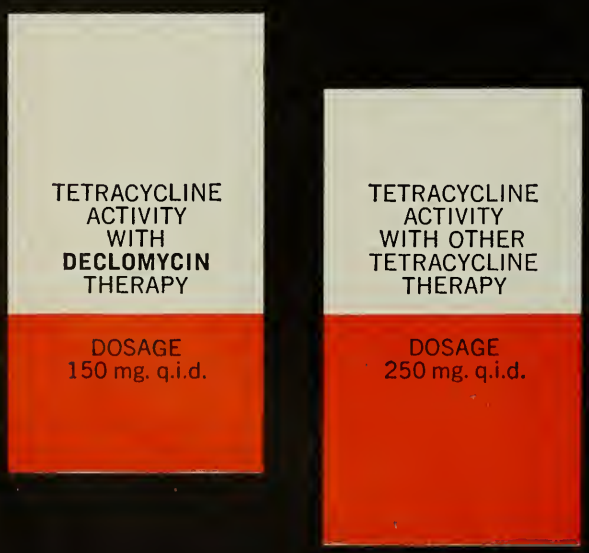
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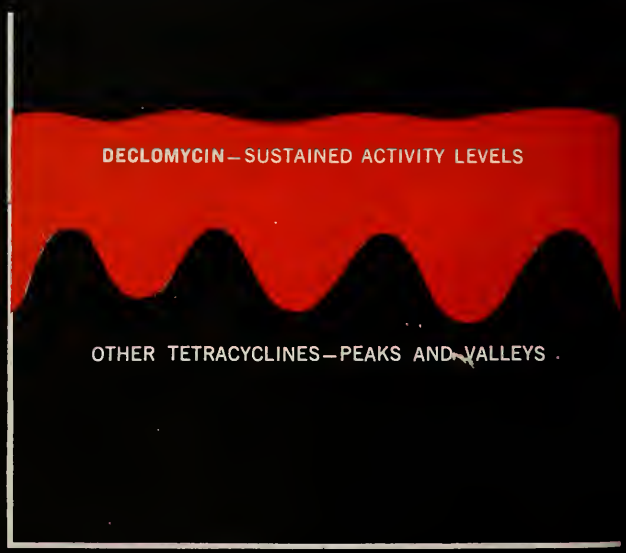
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The
ILLINOIS
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MARCH, 1961
VOL. 119, No. 3

Eating Habits and "Metabolic" Diseases

Clarence Cohn, M.D., *Chicago*

The rate of ingestion of the diet appears to play a significant role in the regulation of intermediary metabolism.[1] Experimental animals forced to consume their daily allotment of nutrients in the form of regularly spaced full meals (meal eaters) differ metabolically from animals eating the same amount of food in frequent small feedings (nibblers). Thus, the meal eater, as compared to the nibbler, exhibits: (a) increased body fat with normal body weight, (b) decreased body protein, (c) altered thyroid activity, and (d) increased hepatic and fatty tissue hexosemonophosphate shunt activity.

From these findings we concluded that the *rate* at which substrates become available must be considered as an additional factor in the influences that govern metabolic activities of cells. We feel that traffic over multiple alternate enzymatic pathways can be altered by changing the manner in which food is eaten; eating patterns seem to influence specific, hence ultimately total, metabolic reactions of an organism.

In the usual study of the interrelationships of fat, carbohydrate, and protein metabolism, attempts are made to achieve the so-called "steady state." For this purpose it has been the custom to control rigidly the quantity and quality of food intake to the neglect of the timing of food ingestion. All but forgotten is the fact that the animal kingdom may be divided into two general types with respect to the manner of food ingestion—the meal eaters and the nibblers. These patterns may be evolutionary vestiges related to the availability of food. Apart from the purely physiological phenomena attendant on eating habits, the consequences of meal eating, if any, should interest civilized man because of his custom of consuming spaced full meals.

With these thoughts in mind, and in view of the results presented above, two general questions occurred to us: (a) Does the manner of eating

Director, Department of Biochemistry, Medical Research Institute, Michael Reese Hospital and Medical Center, Chicago.

The investigations performed at Michael Reese were aided by grants-in-aid from the National Institute of Arthritis and Metabolic Diseases (A-193, C-7) and from the National Science Foundation (G-9992).

While the Nutrition Committee of the Chicago Heart Association is sponsoring this article, the opinions expressed are those of the author and do not necessarily represent the official view of that committee.

have an effect on the production and regression of experimental "metabolic" diseases? (b) How does man react to different eating habits? One might ask also whether experiments designed to explore the "metabolic" diases to which man is prone should not use the eating customs of man, i. e., the "unsteady" state or meal eating condition.

Our continuing studies have been addressed to answering these questions. The results have yielded information suggesting that the rate of ingestion of the diet *does* have an influence on experimental "metabolic" diseases and that man *does* react to eating habits as do other species. Experiments leading to these conclusions may be summarized as follows:

Experimental obesity: The laboratory rat, normally a nibbler, requires 24 hours to consume his ration of food. Force-feeding him his food twice daily converts him into a meal eater. Under the latter conditions, he deposits twice as much body fat but less body protein than does his nibbling control which has eaten the same amount of food and gained the same amount of body weight over the same period.

Experimental diabetes: Effects of manner of ingestion of the diet on the severity of experimental diabetes, one to two months after alloxanization, were studied in rats maintained on constant insulin dosage. In the first weekly period, the animals were permitted to eat *ad libitum:* their food intake and urinary glucose and nonprotein nitrogen excretion were measured daily. The rats were then adapted to force-feeding and fed daily the amount of food they had previously consumed *ad libitum*. Under these conditions, the animals excreted 215 per cent more glucose and 23 per cent more nonprotein nitrogen when meal eating.[2]

Experimental atherosclerosis: Chickens, like laboratory rats, are normally nibblers. By offering the birds food for an hour in the morning and an hour in the afternoon, they may be converted into meal eaters. In both types of eating patterns, the production and regression of experimental atherosclerosis were studied.[3] Meal eating, in induction experiments, was associated with a greater degree of hypercholesterolemia and seven times the incidence of coronary atherosclerosis. In regression studies, meal eating was accompanied by a slower rate of fall of experimentally elevated serum cholesterol levels and healing of established atherosclerotic lesions.

Thus it is possible to demonstrate that eating habits *do* effect the pathogenesis, severity, and regression of some representative experimental "metabolic" diseases.

Man's response to different rates of ingestion of the diet seems similar to that of the other animals studied. Fetuses are, in effect, being supplied by a constant stream of nutrients via the umbilical vessels; the newborn may be properly regarded as a nibbler. Custom, convenience, working conditions and other factors change the eating pattern to one of meal eating. To us it is unnecessary to speculate on man's "natural" eating habits. To do so is to miss the important facets of the problem: (a) *Does* man respond metabolically to the different rates of food consumption as do other species? (b) If man does so respond, *could* patterns of food ingestion play a role in the epidemiology and therapy of "metabolic" diseases? The data now available suggest an affirmative answer to both questions. Initial studies on nitrogen balance[4], thyroid function, and on serum cholesterol levels[5] in man have been performed. The results tend to reinforce our hypothesis that the response to the rate of food ingestion is a general biological phenomenon and that it influences the intermediary metabolism of man in a fashion similar to that of other species.

Assuming the preliminary data will be corroborated, civilized man might start considering means for changing his present eating habits. To accomplish this, diets capable of satisfying physiological and psychological needs must be devised. In addition, a large amount of basic and clinical research must be accomplished.

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Oral Antidiabetic Agents

A review of their pharmacology, mechanism of action, and clinical use

Joseph R. Davis, M.D., *Chicago*

Although the discovery of insulin has provided a satisfactory means of substitution therapy for the control of diabetes, it has also introduced numerous problems for the diabetic patient. Such problems are mainly due to the parenteral route of administration of insulin and include painful injections, dependency upon others for injection of the drug, inconvenience of refrigeration and sterilization, and occasional cases of insulin shock and atrophy of the subcutaneous tissue at the site of injection. It was for these reasons that a long and continued search has been carried out for an oral hypoglycemic agent which would be devoid of the untoward reactions of insulin. The accidental finding in 1918 by Watanabe[1] that the subcutaneous injection of guanidine in rabbits caused a considerable hypoglycemic effect led German investigators in 1926[2] to introduce a diguanidine derivative known as "Synthalin" as an oral agent for diabetes. Although some degree of adequate control could be attained for the diabetic patient with "Synthalin," unfortunately, the drug was soon found to exert serious hepatotoxic and renotoxic effects which precluded its clinical use.

The first major break-through in the field of oral antidiabetic agents came in 1942 with the announcement by Janbon[3] at the Montpellier Clinic for Contagious Diseases in Southern France that a thiodiazole derivative of sulfanilamide, known as IPTD and originally prepared in Germany (1941)[4] resulted in severe neurologic symptoms in patients being treated for typhoid fever. These effects were faintness, dizziness, perspiration, tremor, and disorientation. Janbon correctly reasoned that this syndrome was closely analogous to the picture of hypoglycemic shock and indeed demonstrated an actual fall in the level of blood sugar. A physiologist at the Montpellier Clinic, Loubatieres, was quick to recognize the possible application of the sulfonamide derivatives in cases of diabetes and soon began a long series of publications on the mechanism of action of these compounds which have recently been summarized.[5] In 1954, interest in the aryl sulfonamides spread to Germany; there two new substances were prepared which were closely related to IPTD but lacked the thiodiazole nucleus.[6,7,8] These were carbutamide (BZ-55) and its methylated analogue tolbutamide (Orinase®). Soon after the introduction of these compounds, considerable interest was manifested in the United States for sulfonylurea derivatives of greater potency and duration of action having fewer side effects. A large number of p-chlorobenzene sulfonylureas were synthesized;[9] among these, chlorpropamide (Diabinese®) was found to be the most potent and longest acting compound. A recent departure from the class of aryl sulfonamide derivatives has been the reintroduction of the biguanides as oral antidiabetic agents[10], the most successful being phenethylbiguanide (DBI).

Sulfonylureas

Pharmacology. Tolbutamide and chlorpropamide are rapidly absorbed in the form of the sodium salt, and a maximal blood level is reached in about four hours. They distribute themselves equally in the extracellular fluid; very small amounts of the drug appear in both the bile and the cerebrospinal fluid. In the circulating blood, approximately 50-60 per cent of the drug is bound to protein.[11] Whereas both tolbutamide and chlorpropamide have a latent period of approximately one hour for their hypoglycemic effect, a maximal hypoglycemic response is obtained in five to eight hours with tolbutamide and in only two to four hours with chlorpropa-

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mide. The half-life of the drug in the blood stream is three to four hours for tolbutamide and up to 48 hours for chlorpropamide. Whereas tolbutamide is carboxylated in the p-position to an inactive compound, the presence of chlorine in the p-position of chlorpropamide prevents the occurance of such a detoxication reaction.

Both the unchanged and metabolized forms of the sulfonylureas are excreted via the kidney, the time for excretion of 90 per cent of the drug being 48 and 96 hours for tolbutamide and chlorpropamide respectively. Crystalluria does not occur inasmuch as all forms of the drug are soluble in the urine over a wide pH range.[12] The fact that chlorpropamide attains its maximum hypoglycemic effect in a shorter time period, has a longer half-time in the blood, is not inactivated in the body, and is more slowly excreted in the urine indicates its greater activity as a hypoglycemic agent as compared with tolbutamide. Although closely related to the sulfonamides, neither tolbutamide nor chlorpropamide possess any antibacterial activity.

Mechanism of action. Many theories have been advanced to explain the mechanism of action of the hypoglycemic effect of the sulfonylurea compounds.[13,14] At first the sulfonylureas were thought to have the same mechanism of action as insulin. This has been shown not to be the case inasmuch as the sulfonylureas are completely inactive in producing a decrease in blood sugar when naturally-occuring insulin is absent. While insulin itself may elevate the levels of pyruvic and lactic acids in the blood, the sulfonylurea compounds are devoid of any such action. More- and lactic acids in the blood, the sulfonylurea over, unlike insulin, the sulfonylurea drugs do not enhance the entrance of glucose into skeletal muscle cells as measured by the rate of glucose uptake into the isolated rat diaphragm.[15]

The second theory involves the inhibition by the sulfonylureas of the enzyme responsible for the proteolytic degradation of insulin. This enzyme has received the name insulinase, and after once being thought to be specific for insulin, has now been shown to possess proteolytic activity also toward corticotropin, somatotropin, casein, and glucagon.[16] If the sulfonylureas would inhibit insulinase, it would be expected that more insulin would be available to enhance the intracellular transport of glucose from the blood. The evidence in favor of this theory was based on the fact that the sulfonylureas produced hypoglycemia only in the presence of insulin originating from the pancreas or from exogenous administration. However, it has been exceedingly difficult to prove any inhibition of insulinase since both the measurement of blood levels of insulin and the isolation of the pure enzyme are at present very difficult. In addition, the levels of the sulfonylurea drugs necessary to inhibit crude preparations of insulinase *in vitro* are far in excess of their physiologic dose.[17]

A third theory for the hypoglycemic effect of the sulfonylureas is that these drugs may prevent the formation of glucose from hepatic glycogen, thereby decreasing the release of glucose from the liver cells into the blood. The evidence in favor of this theory is that following the administration of a sulfonylurea to fasted animals, a rapid increase in the hepatic glycogen content was noted.[18] Similarly, the sulfonylureas were found to stimulate the incorporation of radioactive glucose into liver glycogen of fasted animals.[19] It seemed of great interest that neither effect occurred with the hypoglycemic response to insulin. Unfortunately, these results are extremely difficult to interpret in view of the finding that these increases of hepatic glycogen with sulfonylurea administration could not be obtained in fed animals.[20]

A fourth hypothesis implies depression of the function of the alpha cells of the pancreas and assumes that insulin and glucagon are natural antagonists. Glucagon, secreted from the alpha cells of the pancreas, has long been known to be a pancreatic hyperglycemic factor. The observation that the administration of "Synthalin" and IPTD resulted in extensive damage to these alpha cells[21] indicated the possibility of a reduction of glucagon secretion which would augment the hypoglycemic effort of endogenous insulin. However, other investigators have had difficulty in confirming changes of the alpha cells in hypoglycemic states[22] as well as demonstrating any reduction in the extractable glucagon content of the pancreas of animals receiving sulfonylureas.[23]

The last explanation for the hypoglycemic response of the sulfonylureas is perhaps the best founded and most acceptable at the present time. It may be designated as the pancreatotropic effect of the sulfonylureas to stimulate the secre-

TABLE 1.—Comparison of Potency, Excretion, and Dosage of Oral Antidiabetic Drugs

Antidiabetic Drug	Hypoglycemic response			Half-life in blood	Total excretion time	Initial dose	Daily maintenance dose
	Latency	Maximum	Duration				
Tolbutamide	1 hr.	5-8 hrs.	12 hrs.	3-4 hrs.	48 hrs.	3.0 Gm.	0.5-1.5 Gm.
Chlorpropamide	1 hr.	2-4 hrs.	24 hrs.	48 hrs.	96 hrs.	0.25 Gm.	0.1-0.25 Gm.
Phenformin	1 hr.	5-6 hrs.	12 hrs.		24 hrs.	0.025 Gm.	0.05-0.15 Gm.

tion of endogenous insulin from the beta cells of the islets of Langerhans. This theory originated from the work of Loubatieres,[24] who found that in a depancreatized animal, IPTD had no hypoglycemic response, whereas in animals deprived of all but one-tenth of their pancreas IPTD invoked a marked decrease in blood sugar. These observations have been confirmed clinically in that the sulfonylureas are effective in cases of adult diabetics whose pancreas contains adequate amounts of insulin,[25] while having no hypoglycemic effect in either juvenile diabetics whose pancreas contains little or no insulin[26] or in patients whose diabetes is a result of surgical pancreatectomy for pancreatic carcinoma. Moreover, not only do the granules of the beta cells of the pancreas disappear after the administration of a sulfonylurea drug but the amount of extractable insulin of the pancreas is also reduced.[27] It would appear that a major mode of action of the oral sulfonylurea hypoglycemic agents involves the stimulation and release of preformed insulin from the pancreas.

Clinical use. It is of great importance to keep in mind that only selected cases of diabetes are applicable to oral therapy. The clinical indication for sulfonylurea therapy is adult diabetes uncomplicated by acidosis, coma, ketosis, fever, trauma, or surgical procedures. Oral therapy has proved of value in 80 per cent of those patients who have developed diabetes after the age of 40 years.[28]

The contraindications to the sulfonylurea drugs include "juvenile" diabetics who contracted the disease before the age of 20 years, cases of "brittle" adult diabetes, and cases of diabetes adequately controlled by dietary restrictions.[29] During an intercurrent complication the oral sulfonylureas should be withdrawn and insulin therapy substituted for the duration of the complication. It is for this reason that all patients on oral therapy should also be instructed on the proper use of insulin. Moreover, the patient on oral therapy must be instructed not to neglect his dietary restrictions and must be familiarized with the detection and correction of impending hypoglycemia.

Institution of oral sulfonylurea therapy is accomplished by the following suggested dosage schedule. The initial dose of tolbutamide is 3 Gm. on the first day, followed by 2 Gm. on the second day and 1 Gm. on the third and each subsequent day. The initial dose of chlorpropamide is 250 mg. daily with the usual daily maintenance dose being 100-250 mg.

A gradual withdrawal of insulin during the first few days of oral therapy is recommended for both tolbutamide and chlorpropamide. During the withdrawal period a constant check on the urine must be made. The incidence of side effects with either tolbutamide and chlorpropamide is almost negligible and when occurring are almost all of a nonserious nature. The most common include nausea and headache as well as mild allergic skin reactions. Although a 0.4 per cent incidence of jaundice has been reported for chlorpropamide, reversal can be accomplished by the prompt discontinuation of the drug. Moreover, the chronic administration of chlorpropamide to a variety of experimental animals in doses up to twenty times larger than the recommended human dose has resulted in no gross anatomic or histopathologic changes.[30] Unlike insulin, hypoglycemia accompanied by coma is virtually unknown with the oral sulfonylurea agents.

Guanidine derivatives

The first guanidine derivatives to be employed as oral therapy for diabetes, and indeed the first of any oral hypoglycemic agent to be of clinical use, were the alkylated diguanidines Synthalin "A" and "B". Synthalin "A", decamethylenediguanidine, and Synthalin "B", dodecamethyl-

enediguanidine, introduced in Germany in 1926,[2] were used for several years in the treatment of mild to moderate cases of diabetes. Recently, interest has been manifested in biguanides, of which the best known is phenformin (DBI).

Mechanism of action. Reports that "Synthalin" was capable of reducing the blood sugar in completely depancreatised animals have indicated that unlike the sulfonylureas, the guanidine derivatives have an extra-pancreatic site of action.[31] Similarly, DBI produces a hypoglycemic response in animals without a pancreas. Moreover, in contrast to the sulfonylureas, DBI increases the uptake of glucose into the isolated rat diaphragm.[32] However, the exact extra-pancreatic site of action is not known. Numerous theories have been offered and include at the present time such concepts as enhancement of anaerobic glycolysis in peripheral muscle,[33] inhibition of hepatic gluconeogenesis,[34] and inhibition of respiratory enzymes.[32]

Clinical use. DBI has been reported not only to be of therapeutic use in cases of adult diabetes, but also to be of value in cases of "juvenile" diabetes.[35] The insulin requirement for "juvenile" diabetics may be decreased as much as 50 per cent. Still another use for DBI has been in cases of sulfonylurea failures. It seems apparent that although each dosage of DBI should be individualized, low doses should be employed initially, with gradual increases over a period of time until a daily maintenance dose not exceeding 150 mg. is attained. Like the sulfonylureas, DBI is contraindicated in the acute complications of diabetes. The side effects of DBI are related to the gastrointestinal tract and include anorexia, nausea, vomiting, and occasional diarrhea. Although these symptoms may be sufficiently severe to discontinue therapy in a small number of patients, they usually disappear upon reduction of the dosage of the drug.

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Annual Meeting Program

in the April Journal

Occupational Diseases of the Skin Among the Farmers of Illinois —

A Symposium

Hans M. Buley, M.D., *Champaign,* Chairman;
George Dickison, M.D., *Peoria;* and
Malcolm Spencer, M.D., *Danville*

Chairman's Introduction

During the past three decades industrial medicine has made many important advances in recognizing the causal relationships between certain occupations and disease and in the prevention of occupational hazards. Little attention, however, has been paid to the occupational injuries and diseases among the farmers, particularly to the dermatoses associated with their work.

The reasons for this lack may readily be seen. The majority of the great industrial plants was concentrated in and around the major metropolitan areas where specialists in the field of occupational medicine were easily available. Both industrial management and labor were interested in limiting occupational hazards among their workers for reasons of mutual benefit. Because of this, large funds were made available to conduct extensive studies in this field. Contrariwise, the farming population was spread out over vast rural areas. Disease and accident on the farm remained a private problem between the patient and the family doctor, and therefore, only scattered attempts were made to protect the farmer against the hazards of his trade particularly from the dermatologic point of view.

However, as one becomes aware of the rapidly growing industrialization of agriculture due to modern intensive farming techniques, the constantly progressive mechanization of equipment, the use of many new synthetic chemicals, such as fertilizers, preparations for the treatment of seed, compounds added to the feed, insecticides, weed killers, cleansing agents and others, one realizes that the farmer is at least as much exposed to the possibility of occupational disease as the industrial laborer. Indeed, from an economic viewpoint, such disease or injury may be more disastrous, because a farmer cannot as easily be replaced in his job as an industrial worker, and oftentimes he cannot afford — not even for reasons of health — to interrupt his seasonal work at a critical time of the year, lest he lose a large portion of his year's earning.

The physician who practices in a farming area is very much conscious of this situation and has to deal with its problems constantly, at times with a great amount of frustration and exasperation. In no field of medical endeavor, therefore, should the value of prevention be rated more highly than in that of occupational diseases among the farmers.

The Climatic Dermatoses

Hans M. Buley, M.D., *Champaign*

The climatic dermatoses may be defined as diseases resulting from a lack of adaptation of a healthy person's skin to the weather. If one defines "weather" as the sum total of atmospheric conditions or changes — including temperature and pressure, wind velocity and direction, humidity, cloudiness, and precipitation of rain, snow or hail, atmospheric ionization, and the amount of solar radiation and its components — one becomes aware of the complexity of the problem in question. Although the literature dealing with certain phases of the problem, such

*Presented before the Dermatological Section of the Illinois State Medical Society, Chicago, May 26, 1960.

as the effect of ultraviolet rays on the skin, is extensive, the actual knowledge of the subject as a whole is still fragmentary. One must be cautious, therefore, in the interpretation of observations, and one should avoid the customary loose usage of "wind and weather" as an explanation for certain clinical phenomena.

In discussing the occupational character of the dermatoses due to the climate, I will include only the damage of the healthy skin due to cold, to heat and humidity, and to solar radiation.

Among the dermatoses caused by the influence of *cold,* we distinguish between the acute forms of true cold damage, called "frost-bite," and the more chronic conditions, the "chilblains" or "perniones," and "trenchfoot." Chilblains and trenchfoot are extremely rare among the farmers of Illinois, partly because the winter work on the farm is usually limited to jobs performed in the barn or other farm buildings, and partly because the well-fed and warmly-clothed farmers are sufficiently protected against such disease. Acute frost-bite, however, will occur, though usually to a minor degree, on face, ears, hands, and feet, after occasional work in extreme cold and wind. Usually the area of involvement shows a diffuse erythema, which even after return of the patient to an environment of moderate temperature persists in a form of a passive hyperemia, often associated with marked burning or itching. A moderate hypersensitivity to temperature changes may remain. A more severe frost damage with vesiculation and necrosis may occur under special circumstances, of course, but such conditions are certainly not common as occupational injuries on the farm and may, therefore, be passed by here.

Much more disturbing and less avoidable are the summer dematoses resulting from the extreme *heat* and *humidity,* which are so typical of the climate of Illinois during the busy months of field cultivation and harvest. As a physiologic response to the rise in body temperature, the rate of sweat production increases and the composition of the sweat changes. Aside from infections, the appearance of "miliaria rubra" or "prickly heat" is a common occurrence. This eruption consists of numerous pinhead-sized maculopapular, or, at times, vesiculopustular erythemas surrounding the sweat pores. The areas of predilection are the trunk and the extremities, especially where the clothes fit tightly, as in the axillae, the groins and around the waist. The rash is of no serious consequence, except that it may cause intense itching which disturbs the few hours of sleep a farmer is able to get during the periods of highest farming activity. Scratching of the eruption also furthers the ever present danger of infection, and occasionally furunculosis or an extensive disabling intertriginous dermatitis may complicate the primarily innocuous dermatosis.

Preventive measures against miliaria are easy to apply. Miliaria-prone individuals should wear light, sweat-absorbent, and loosely-fitting clothing which allows for sufficient ventilation of the skin, and which should be changed often. The same modalities used for the treatment of miliaria rubra may be used prophylactically, such as frequent cool baths, drying antiseptic dusting powders, or drying lotions.

"Farmers' skin" and senile dermatoses

By far the most common, and unfortunately the most ignored, truly occupational dermatosis among the farmers is the condition traditionally referred to as *"farmers' skin."* It is so common that most farmers accept it as normal and pay no special attention to it. Essentially, "farmers' skin" is an epidermal atrophy associated with certain changes in the upper level of the corium. It occurs on the exposed areas of the body. Not infrequently it can also be found on the shoulders and upper back, when these areas have been subject to repeated sunburns. In the early stages of the disease, a diffuse redness of the skin, telangiectases, and pigment irregularities are the only signs. Later on, a peculiar whitish-yellow mottling of varying degree becomes noticeable and gives the skin a variegated or marbled appearance, until finally, in advanced cases, a spotty waxy discoloration can be observed. While on the nose and the cheeks the skin is somewhat thinned and stretched, the temples and posterior neck may show a marked thickening of the skin with coarse wrinkles and deep folds (cutis rhomboidalis nuchae). The forehead, however, which is usually in the shadow of the hat or cap, shows characteristically a perfectly normal skin.

Sooner or later in the life of the patient with "farmers' skin" fairly well defined, slightly scaling red patches of varying size and shape develop. These lesions are traditionally referred to as

"senile keratoses" but the terms "actinic" or "solar" keratoses are much more appropriate inasmuch as the lesions may develop as early as in the twenties or thirties. On the face the scaling on these keratoses is usually not conspicuous or may be absent; but on the neck and on the extensor surfaces of the arms and hands, thick, adherent, horny scabs may form. At times an underlying inflammatory infiltrate may give these lesions a papular appearance and a firm consistency that renders them clinically indistinguishable from early cutaneous carcinoma.

The older textbooks of dermatology, in describing "farmers' skin," followed the popular concept of explaining the dermatosis as a part of the aging process of the skin "under the influence of wind and weather." Modern clinical and histologic investigations, however, have shown convincingly that the aging of the skin and the changes of "farmers' skin" are basically different and should be clearly distinguished from each other. Obviously, since the change of "farmers' skin" take place only in areas of sun-exposed skin, the physiologic process of aging as such cannot be its cause. Indeed, many farmers who develop the dermatosis in their prime of life would consider it absurd and ridiculous to hear that the condition of their skin is a sign of senility.

The decisive pathogenetic factor is not the patient's age, but the amount of pigment present in his epidermis and its ability to darken. Negroes do not develop the dermatosis at all. Swarthy individuals rarely do, but the fair and blue-eyed persons who sunburn easily are certain candidates for the disease. To complete the evidence in favor of the case for solar radiation being the cause of "farmers' skin," there is evidence that in the lower latitudes people with poor tanning ability show it at an earlier age and more fully developed than in the regions farther north.

The results of scientific investigations with the ultraviolet portion of the solar spectrum (about 2,800 to 3,200 Angstrom units) confirm our clinical impression concerning the effect of solar radiation on the skin. Whatever influence, if any, other meteorological energies have, is still unknown at the present time.

Following repeated and prolonged exposures to the sun, which are inherent in farming, degenerative changes at the subpapillary level of the cutis take place. These changes have gained increasing attention in recent years with regard to the pathogenesis of solar damage and its complications. The thickened epidermis and increased pigmentation which result from ultraviolet exposure absorb a large portion of the rays, act as a self-protective mechanism. A fraction of the ultraviolet, however, estimated to be 1 to 10 per cent of the total, does reach the cutis and causes a response at the subpapillary vascular plexus. The collagenous fibers surrounding the vessels begin to swell, become increasingly curled and twisted, and their histologic staining qualities gradually change to a basophilic pattern. Finally, in the fully developed dermatosis, a matted layer of amorphous material is spread throughout the sub-epidermal region. In modern histologic terminology this state is described as "actinic" or "solar" elastosis.

Treatment and prevention

It is logical, then, to assume that the epidermis, which depends on the underlying cutis for its nutrition, eventually suffers because of this sub-epidermal elastosis, becomes atrophic, and the process of regeneration and keratinization may be disturbed. The result is atrophy, the formation of dyskeratotic patches, which are the clinically observed "solar keratoses," and oftentimes malignant degeneration of the epidermal cells. Solar elastosis and epidermal atrophy are irreversible changes, and no effective treatment for them is known. Nor is there any known modality which prevents solar keratoses and cancer on skin damaged by solar action, except perhaps the avoidance of additional sunburning.

Were it not for the precancerous quality of "farmers' skin" the dermatosis would be of interest only to the student of skin diseases. The frequent occurrence of cutaneous carcinoma, however, on the terrain of solar damage should attract the attention of all physicians, particularly those practicing in the rural areas. Fortunately, skin cancer can be diagnosed early, and thanks to the extensive propaganda campaign against cancer in recent years, the rural population is sufficiently educated to consult the physician as soon as abnormal changes in the skin are noticed. The majority of the lesions, therefore, receive treatment at an early stage, and hence, the therapeutic results are excellent.

Preventive measures, of course, are all impor-

tant. But how, one may ask, can one hope to prevent solar damage to the skin of a person whose job demands his presence out in the open with exposure to the sun from the earliest spring to the late fall? It seems to be an impossible task. Nevertheless, there are a few things which can be done. Foremost is the education of the farming population to the dangers of solar radiation, a point which is still understood by all too few. Next, adequate protection from the sun, especially during the midday hours, may be sought in the form of light clothing coverage, including the arms and neck, and the wearing of a large hat. Cumbersome and inconvenient though these garments may be to the farmer riding a tractor or a combine on a windy or hot day, they will serve their purpose well. Frequently umbrellas and awnings are now used on tractors and other farm machinery. Protective creams and lotions, if applied to exposed areas before work, are valuable preventive agents, especially in spring before the skin has a chance to develop its own protection. If fashion and personal vanity will ever permit, a handsome beard could provide a great deal of natural protection to its wearer's face and neck. Finally, the antimalarial drugs, which reduce sensitivity to the burning ultraviolet rays, or the psoralens, which stimulate pigmentation and cause melanin retention in the epidermis, promise to become effective prophylactic agents. Provided that future observation on a large number of patients prove these drugs safe when taken over long periods of time, oral prophylaxis might eventually solve the problem of solar damage to the skin among the farmers.

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Cutaneous Infections

George J. Dickison, M.D., *Peoria*

Certain infections of the skin occur with greater frequency in farmers and farm workers than in the general population. These infections usually result from contact with infected animals. The incidence of some infections, such as bovine tuberculosis, anthrax, glanders, and brucellosis, has greatly diminished during the past 30 years. This has been achieved by extensive testing, rigid control, and destruction of all infected animals. The more common infections will be discussed here. A brief description of the disease, its etiology, diagnosis, and treatment will be covered.

The most common animal infection which produces skin disease in man is animal ringworm. Tinea capitis, tinea corporis, and tinea barbae can all result from an infection with one of the dermatophytes from animal contact.

Tinea capitis can be caused by various species of fungi: *Microsporum canis, Microsporum gypseum, Trichophyton mentagrophytes,* and *Trichophyton verrucosum.* As a rule zoophilic fungi produce more inflammatory lesions than do the fungi which naturally occur in man.

An exception to this rule is sometimes seen in tinea capitis caused by *Microsporum canis.* In this instance the infection can be indistinguishable from those due to *Microsporum audouini* in terms of the clinical features, direct microscopic findings in the hair, and fluorescence. *M. canis* usually comes from an infected kitten, although puppies, cows, horses, and sheep can also be the source.

M. gypseum infections are uncommon; but when they occur they are characterized by marked inflammation and the formation of a kerion, a boggy granulomatous, tumor-like lesion with much pus. This organism occurs in the soil as a saphrophyte.

Trichophyton mentagrophytes causes severe infections of the skin, scalp, and beard. It occurs in cattle, horses, and cats; it can also be isolated from the soil. The zoophilic strain causes very severe infections and is apparently a different strain from the one which causes human tinea pedis.

Tinea barbae or ringworm infection of the beard is the result of *T. mentagrophytes* and *T.*

verrucosum. This latter fungus comes from infected cattle and feeder calves.

Tinea corporis can be produced by any of the above fungi; the lesion is usually markedly inflammatory as in the scalp and beard. Diagnosis rests on demonstration of fungus spores or hyphae in the infected hair, pus, or skin and by culturing the fungus on special media.

The Wood's light is of use in the diagnosis of *Microsporum canis* infections since the infected hairs have a characteristic greenish fluorescence just as they have in the human ringworm of the scalp. Other types of tinea capitis do not have a characteristic fluorescence.

Treatment includes soothing, warm compresses if there is much inflammation and kerion formation. Systemic antibiotic therapy is indicated if much suppuration is present. All infected hairs should be gently epilated. When the acute inflammation has subsided, a mild fungicidal ointment, such as 3% sulphur is used. Griseofulvin®, 500 mg., twice daily, can also be given although it has been my impression that the course will not be greatly shortened.

Dairy workers who have their hands wet a great deal of time in the course of washing the cows udders and the milking equipment are susceptible to *Candida albicans* infections of the hands and paronychial regions. Microscopic examination of infected material is usually negative, and cultures are necessary for diagnosis. Treatment consists of topical Mycostatin®. Gentian violet is on occasion still helpful. Oral Mycostatin is of no value because it is not absorbed from the intestinal tract. Keeping the hands dry is of prime importance in effecting a cure and preventing a recurrence.

Deeper fungal infections also occur in farmers, for example, sporotrichosis, actinomycosis, and nocardiosis. The most common form of sporotrichosis is the lymphatic characterized by a group of subcutaneous nodules and ulcerations extending along a lymphatic channel. Treatment consists of saturated potassium iodide solution, 10 to 30 drops, three times daily. Improvement occurs in about two weeks, and medication should be continued for a month after all lesions have healed. A course of therapy will usually last three months.

Erysipeloid is essentially an occupational disease of people who incur abrasions while handling infected organic material. It is seen in farmers who do their own butchering and also in farm women who cut their hands while dressing poultry. It is also encountered in veterinarians who have had contact with infected swine. The causative organism is *Erysipelothrix rhusiopathiae,* which will survive for months in the soil or decomposed organic material. The disease has three forms:

1. The most common—a localized cutaneous form lacking constitutional symptoms.
2. A generalized eruption with mild symptoms.
3. A rare systemic form with endocarditis.

The common cutaneous form usually occurs on the hands and is characterized by vivid inflammatory marginated lesions with central clearing. It looks like erysipelas, but the patient is not sick. Penicillin is very specific and curative.

There is a pox-like disease of the cow's udder which can be transmitted to man, causing milker's nodules. This is almost unknown to city physicians, but farmers and veterinarians are usually familiar with it. The disease is acquired from an infected cow and is due to the paravaccinia virus. There are usually just a few lesions on the fingers. They reach their maximum size in two weeks and form a firm purple nodule. The center may umbilicate. The lesion does not become painful nor pustular, thus differentiating it from cowpox. No treatment is necessary as the lesions heal spontaneously in several weeks. There is no cross immunity with vaccina. With modern methods of machine milking and rigid inspection of cows, the incidence of this disease has become quite low.

Another rather rare condition is orf. This is primarily a viral infection of sheep and occurs as a vesicular eruption of the mouth and lips. In man it occurs in the form of inflammatory vesicles and pustules and usually is found on the hands. Spontaneous healing occurs within three weeks. There is little systemic reaction or regional adenopathy in spite of the rather severe appearance.

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Occupational Dermatitis and Eczema Among Farmers

Malcolm C. Spencer, M.D., *Danville*

With the adoption of modern farming methods, the occupational hazards of the farmer have increased. Automation and the widespread use of chemicals have added tremendously to the already formidable list of naturally occurring potential allergens to which he is exposed (Tables 1 and 2).

Despite this increase in contactents, the incidence of truly allergic reactions remains surprisingly low. The problems of occupational dermatitis seen most often remain chiefly those recognized for many years. Only an occasional case is due to sensitization to the newer group of contactents. Table 3 summarizes cases in present study.

TABLE 1.—Common Weed Sensitizers Indigenous to Illinois

Burdock	Pigweed	Wild Carrot
Cocklebur	Poison Ivy	Wild Garlic
Dogfennel	Primrose	Wild Geranium
Goldenrod	Ragweed	Wild Morning Glory
Jimson Weed	Redtop	Wild Parsnip
	Smartweed	

This listing taken in part from *Just Weeds,* E. R. Spencer, Charles Scribner's Sons, 1957, and Hugh Graham, Inc., Allergic Laboratories, Dallas, Texas.

TABLE 2.—Chemical Occupational Hazards in Grain Farming

Fertilizers
Nitrates, Phosphates, Potash (variable proportions).
Insecticides
DDT, Lindane, Aldrin, BHC, Dieldrin, Endrin, Heptachlor, Toxaphene, Malathion, Methoxychlor, Phosdrin, Parathion, Rotenone, Rotenone-sulfur.
Fumigants
DDT, Methoxchlor, Ethylene dichloride, Carbon disulfide, CCl_4.
Pre-emergence Herbicides
Falone 2,4, Randox, Simazine, Amiben, Randox-T, Antrazine, Alanap.
Post-emergence Herbicides
2-4-D

This listing based on various bulletins of the Extension Service in Agriculture and Home Economics, University of Illinois, College of Agriculture, Urbana.

Associate professor of dermatology, Northwestern University School of Medicine.

TABLE 3.—Occupational Dermatitis Among Farmers Based on a Review of 2851 Current Office Records

Source	No. of Cases
Ragweed	10 (1 atopic)
Weed Killer	4
Fertilizer	1
Insecticides	1
Seed Treatment	2
Cattle	3
Other Weeds	1
Miscellaneous (cement, chrominum, leather, soap, etc.)	9
	31

Poison ivy

Poison ivy dermatitis continues to be the most frequently seen allergic contact reaction. There is, however, little difference in the incidence in urban and rural areas. It is not the occupational hazard in farmers that one might expect it to be. Most of the cases seen are in children or young adults, whether living on the farm or in town. It is unusual to see it as a recurrent problem interferring with a farmer's work. When it does occur to this degree, a short course of corticosteroids will result in a dramatic recovery. It has not been necessary, in my experience, to use extracts as a means of desensitization. However, this is not true in children or young adults, who seem to obtain benefit with prophylactic desensitization in selected cases. The extracts should never be used as treatment during the acute phase.

Ragweed dermatitis

Ragweed dermatitis, while much less frequent than poison ivy, is the most important occupational dermatitis seen in farmers in my practice. This is not a self-limited eruption. Its course is one of persistent activity, usually in such a degree as to interfere appreciably with the victim's occupation. It is seen in two forms.

As a pollen inhalent, the protein fraction can occasionally cause an atopic dermatitis with typi-

cal distribution on the neck, eyelids, and anticubital fossae. The scratch and intradermal tests are positive in these cases, but the patch test to the oleoresin is negative. This particular form is rare in this area but is reported to be not infrequent in California.[1]

Ragweed dermatitis in this area is caused by sensitization to the ragweed oil — the so-called oleoresin or the alcohol-ether soluble fraction of the plant.[2] It usually appears towards the end of the ragweed season but generally persists many weeks, even months, after frost with frequent unexplained exacerbations. The open type of patch test may be negative. If this occurs, a closed patch test to the oleoresin should be performed. Cross sensitization to chrysanthemum, turpentine, and tobacco has been proposed as an explanation for the marked chronicity of this eruption.[3] In my experience, however, this cross sensitization has not been observed on repeated patch testing. The most likely reason for continued activity is that exposure inadvertently occurs from grains and feeds contaminated with the ragweed. Another interesting feature of ragweed dermatitis is that it appears for the first time in the 40 years or older age group (Fig. 1). Table 4 compares salient features of ragweed dermatitis, poison ivy, and polymorphous light eruptions.

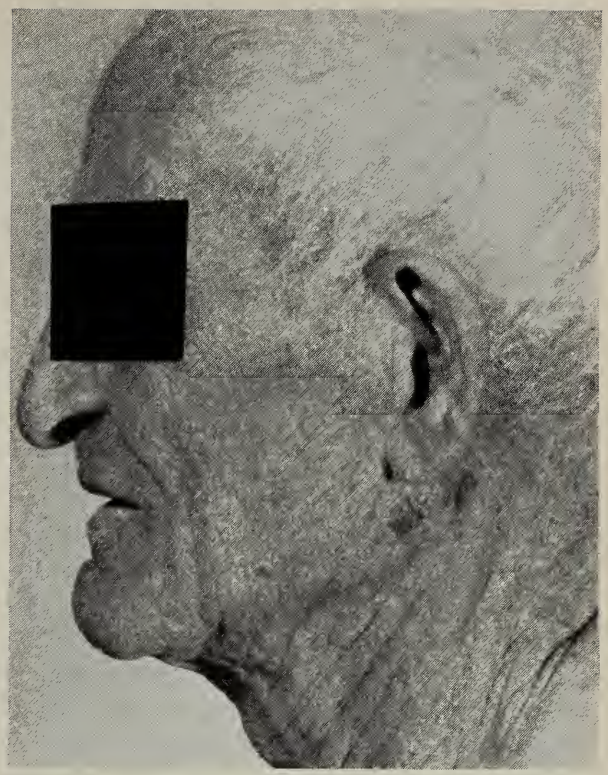


Figure 1. Ragweed dermatitis. Indurated erythema with secondary eczematization.

Milker's eczema

I agree with Epstein that while this is a clinical entity, it is most likely an atopic dermatitis due to sensitivity to cattle. In the characteristic form, as described by Epstein,[4] the eczema involves the thumb and index finger of the right hand and extends to the radial aspect of the wrist. Later on, the left hand is similarly involved but less severely so.

In some instances there is an associated dermatitis of the anticubital areas and of the eyelids or face. An acute form due to weeds has been described.[4] However, in contrast to ragweed contact dermatitis, Milker's eczema first appears in persons 20 to 40 years of age.

In support of Epsteins' argument that this is a clinical entity, the connection with milking or contact with cattle is often apparent to the patient. For example, the three patients in the present group had definitely associated their trouble with contact to cattle before seeking help. However, while hand involvement was present in two, one of these had noticed initially, an anticubital dermatitis which he felt was the result of cleaning milking utensils and the cows' udders. He has been able to get along fairly well, despite

TABLE 4.—Salient Features of 3 Dermatoses Among Farmers

Features	Ragweed	Polymorphous Light	Poison Ivy
Age of Onset	40 or older	Adult	Child
Sex	Male	Both	Both
Initial Episode	Fall	Spring	Spring
Distribution	Face & Arms	Exposed Surfaces	Areas of Contact
The Eruption	Indurated Erythema	Polymorphous	Typical & Atypical
Duration	Chronic	Clearing after frost	Self-limited
Complications	Common	Occasional	Frequent

having to continue milking, with a protective regime and taking an antihistamine. But with any significant recurrence, local steroids are necessary for symptomatic relief. The second patient with hand involvement developed dermatitis after getting a single milk cow. His dermatitis cleared after selling his cow. The third patient had periorbital dermatitis, recurrent with minimal exposure to cattle.

Discussion

In 1953, I presented an exhibit at the American Academy of Dermatology and Syphilology entitled *Dermatology R.F.D.* In this exhibit, it was pointed out that certain cutaneous manifestations are seen with much greater frequency in rural than in urban areas. As part of the preparation for this presentation, it was interesting to review this exhibit with special reference to the cases of occupational dermatitis among farmers. For example, a swine herdsman with an eczematous contact dermatitis to penicillin used in treating sick hogs developed sensitization to the antibiotic. It is the only case I have seen and recognized. Yet antibiotics such as penicillin, streptomycin, and neomycin with well recognized indices of sensitization are being used with increasing frequency by farmers in the treatment of animals. A man with severe dermatitis to corn (patch test positive) required hospitalization on three occasions for symptomatic treatment. He was later found to have a leather sensitivity. The eruption cleared completely when he avoided wearing leather shoes. Finally, a soil conservation employee had weed dermatitis. It began in the early summer and was characterized by repeated bouts of periorbital dermatitis. He has since had minimal difficulty by taking repeated courses of poison ivy extract.

Thus, it must be realized that frequently it is necessary to change one's concept of the role of suspected allergens in cases of chronic and recurrent occupational dermatitis. The continued study of the patient with a persistent occupational dermatitis, in addition to symptomatic therapy, is likely to result in a significant revelation that will be most gratifying.

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Symbols of medical practice

You all remember the "Gold-Headed Cane" that was carried by the leading London practitioners in the seventeenth and eighteenth centuries as a symbol of their knowledge, authority, success, and elegance. These men had prestige, but they were artists, not scientists, although they were patrons of science. But as Dana Atchley pointed out: "The art of medicine (at that time) was so devoid of scientific knowledge that pomp and ceremony were highly useful therapeutic adjuncts."

There was also a symbol for the outstanding country practitioner who drove a horse and buggy from house to house to care for his patients, and that was a "Whip with the Silver Handle." Perhaps one of the finest of these doctors was Edward Jenner, who observed and realized the significance of cowpox on the fingers of milkers in relation to resistance to smallpox and who developed the first specific immunizing procedure in man — vaccination. Although its symbolism has changed somewhat, the "Gold-Headed Cane" may still be found in many of our clinics and laboratories. I hope that some of our clinical investigators will continue to be those who figuratively carry the "Whip with the Silver Handle." *John H. Dingle, M.D. The Whip with the Silver Handle. J. Lab. & Clin. Med. January 1961.*



Cook County Hospital

The Management of External Small Bowel Fistulas

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Discussants:
WILLIAM GROVE, M.D.
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IRVING F. STEIN, JR., M.D.
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Dr. Robert J. Baker: The occurrence of a postoperative small bowel fistula is a catastrophic, often unanticipated complication that surgeons must occasionally face. The mortality rate ranges between 20 and 30 per cent, and under optimal circumstances, prolonged invalidism is certainly the rule. Once the fistula is established, the symptoms may be primarily local, or the patient may quickly be reduced to desperate straits or complete collapse by virtue of immense losses of fluid, electrolytes, and protein, depending largely on the size and location of the fistula.

All of these patients require the utmost in judgment and experience in their management, and we feel that our discussants today can shed considerable light on these terrible problems. Dr. William Grove, associate professor of surgery and attending surgeon at the University of Illinois College of Medicine and Research and Educational Hospital, was formerly an associate attending surgeon in this hospital, and was as highly regarded by the residents then as he is now; since the resident group is a notoriously critical one, we feel that this is as strong a recommendation as one can have. Dr. Irving F. Stein, Jr., is attending surgeon at this hospital and assistant professor of surgery at Northwestern University Medical School. Dr. Stein, too, merits the unanimous acclaim of our severest critics. We hope to draw on the experience of these surgeons in solving some of the problems to be presented.

Case 1

Dr. Edward Quartetti, surgical resident: A 37 year old Negro female was admitted to the surgical service with a five day history of cramping lower abdominal pain and nausea, but no vomiting. She had commenced passing clots per vagina on the second day of illness and felt this to be an atypical, early menstrual period. No placental tissue was passed.

Physical examination revealed tenderness in the right lower quadrant, marked distention of the abdomen, hyperactive, high-pitched bowel sounds, and on vaginal examination, a large uterus was palpated, firm and slightly tender.

Roentgenograms revealed air fluid levels in the small bowel. Barium enema was negative, and surgical exploration was advised. At surgery a

twisted right uterine fibroid was found, as well as subacute pelvic inflammatory disease. The fibroid was removed. The patient tolerated the procedure well and was discharged on the tenth postoperative day, doing well, with skin sutures removed.

She returned to the hospital on the following day with the information that the wound had opened spontaneously the night before, emitting copious amounts of green fluid which, she said, "bubbled out." On observation of the wound, large quantities of green, watery fluid drained spontaneously with some recognizable food particles.

Dr. Baker: The x-ray pattern was interpreted by the surgeon and the roentgenologist as substantiating the clinical picture, showing organic small bowel obstruction, and the patient was explored. Several loops of mid-ileum were adherent to the inflamed tube on the right, but an actual obstructing band was not found. However, the fibroid was removed, and the patient was considered to have made a complete recovery when she was discharged.

On readmission to the hospital, a short transverse incision which had been closed in one layer with double wire was granulating, and some greenish-yellow fluid was issuing from the wound. A drain was placed in the wound and continuous suction was applied. Fortunately she did very well. After about a week the drainage rapidly diminished, the wound granulated in, and in 10 days the fistula was closed. This was a very happy result, but the question that arose is one that we will pose to our discussants: At what point can you decide which fistula will close, and what do you do with a small fistula like this?

Dr. William Grove: Was the bowel itself opened at any time? Was it adherent to pelvic structures?

Dr. Baker: Yes, very loosely. No actual adhesions were cut; the bowel was opened for decompression by 1 cm. enterotomy, and this was closed with two layers of sutures, catgut and silk.

Dr. Grove: One is interested immediately in the cause of the fistula. Primary among the causes of small bowel fistula following surgery is an accident with regard to the surgery itself, such as roughness in handling the tissues. This patient had a moderately distended bowel and it would not have been remiss to have done an enterotomy and put a suction tube in to decompress the bowel; this makes closure of the abdomen easier and the postoperative course smoother. There was some suggestion of adhesions in the pelvis. Even though they were struck off or swept off with the surgeon's hand, sometimes there are tears in the serosa, or even the muscularis. If the surgeon makes a quick inspection and sees that the bowel is not open, he will pass it off as unimportant, particularly if it is a small area. I think these areas should be sutured; that is, any torn serosa should be sutured because, if the distention continues or increases, the area could be the site of a perforation.

I was interested in the closure of the abdominal wall. I understand it was through-and-through peritoneum and fascia; the skin was closed separately. This is a little different from the true through-and-through closure, but not a great deal. We have seen fistula develop from through-and-through closure because of the bow-string effect of a deep suture across the "V" of the peritoneal closure. This effect is particularly apt to occur if the suture does not go in perpendicular to the abdominal wall, but rather goes in at an angle. If the bowel is distended against the suture and if there is no bowel activity, erosion or frank cutting of the bowel can occur. A loop of small bowel can also be caught between the suture and the abdominal wall.

This patient is said to have had pelvic inflammatory disease. Such cases are notorious for developing fistulas spontaneously following surgical manipulation within the pelvis. Abscesses develop which may erode into the bowel and also out through the abdominal wall. We have seen patients with half a dozen fistulas in the abdominal wall and all they have had is severe pelvic inflammatory disease with some operative intervention.

How wide open was this fistula? Were both ends of the bowel open?

Dr. Baker: The fistula was not visible in the wound.

Dr. Grove: For any fistula to close, it is axiomatic that there cannot be obstruction distal to the point of the fistula. This is most important in colon fistulas because these cannot heal spontaneously if there is distal obstruction. Half of colon fistulas will close spontaneously, but the higher the fistula, the less likely is this to hap-

pen. High jejunal fistulas will rarely close spontaneously, and ileal fistulas do not do so often.

I think you are fortunate that you did not have to reoperate this patient. One of the things I would caution against is trying to occlude the fistula with some kind of an appliance, such as a Foley catheter. It seems like an ideal thing to do, and sometimes it is tried. However, usually the fistula becomes larger. In my experience, there should be no more manipulation of the bowel than aspirating away of material to decrease the amount of destruction from digestion. Anything more than that has led only to more destruction of the bowel and a bigger fistula. T-tubes have been devised to bridge the defect, but again I have not been successful in accomplishing this.

Immediately upon suspecting a fistula, some kind of drainage should be instituted so that digestion of skin is kept at a minimum. Aluminum paste is effective only as long as the skin is intact. Once the epidermis is destroyed, aluminum paste will not do much good. Most of the pastes that are available are not very good because the digestive secretions tend to erode beneath them.

Dr. Baker: We have been most discouraged with the use of aluminum paste but have used instead a mixture of equal parts of protein hydrolysate powder and egg white. This becomes thick and pasty when mixed together and can be painted on a granulating surface where it will dry and form a thick crust. The proteolytic enzymes in the small bowel utilize this protein mixture as a substrate, and the skin will heal beneath it. Some silicone preparations have been used with success, but most, like aluminum paste, will not adhere to the wet surfaces.

I have two questions to ask: (1) Should this patient be put on gastric suction in an attempt to decrease the fluid passing through the fistula? (2) If we feed her, what should it be?

Dr. Grove: That depends on how low you estimate the fistula to be. If it is low, then I think the patient can be fed. When it is high, you are not gaining much by feeding the patient; yet this is the patient you would like most to aliment. Sometimes with a high fistula we have inserted a long intestinal tube, threaded it down the bowel, past the fistula, and fed the patient by this route. As to the type of food, in someone like this I would encourage a diet high in protein, and all that she would take.

Dr. Irving F. Stein, Jr.: I don't think there is any argument about the treatment of this case. The patient recovered nicely. She was fortunate that she did so well. The only possible discussion I can raise in terms of an argument is a question of the diagnosis of bowel obstruction. Why is it called small bowel obstruction with a moderate amount of gas in the cecum on the x-ray?

Dr. Meszaros: I think it was an incomplete obstruction.

Dr. Stein: I would agree with that. The differentiation between a paralytic ileus and small bowel obstruction which is incomplete is a very delicate one and sometimes cannot be made.

Dr. Baker: Apparently the obstruction was subsiding. She was watched for 36 hours. She never had frank peristaltic rushes, but the distention did not abate; x-rays were taken, barium enema was done, and since she had no scars or hernias, it was felt that it would be dangerous not to explore her.

Dr. Grove: Would you consider it important that she had no vomiting, in spite of distention?

Dr. Stein: It is unusual not to have vomiting in small bowel obstruction. Those that do not vomit are usually obstructed lower down.

Case 2

Dr. Marvin Tiesenga, surgical resident: The patient was a 55 year old Negro male admitted to the surgical service with a history of intermittent right upper quadrant pain and vomiting, three or four times daily for three days, and marked abdominal distention of two days' duration.

Physical examination revealed marked abdominal distention, hypoactive, high-pitched bowel sounds in rushes, and moderate tenderness throughout. Roentgenograms were suggestive of small bowel obstruction with large laddered loops of bowel seen.

The patient was explored, and a band in the right lower quadrant was found obstructing the mid-ileum; this was lysed. Enterotomy was performed in the midjejunum for decompression and to facilitate closure; the bowel was threaded on a Poole suction tube, and aspirated. The enterotomy was closed with a purse string of fine silk, and this was oversewn with several fine silk

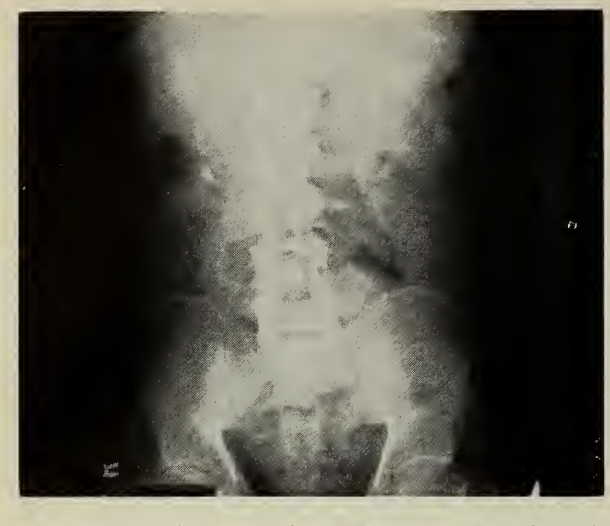


Figure 1. Flat film of the abdomen, showing dilated loops of bowel and radiodensity in the right upper quadrant.

seromuscular sutures. The wound was closed with doubled stainless steel wire.

Postoperatively there was transient oliguria and moderate tachycardia. On the sixth postoperative day a wound infection developed, but on the tenth day the wound commenced draining thin, bile-stained material.

Dr. Baker: This patient was seen by several consultants prior to surgery and was observed for several days. We thought he had a small bowel obstruction, but there were several things on the films that delayed operation. I think we should view the films now.

Dr. Meszaros: The first film (Fig. 1) shows a few distended loops of small bowel in the mid-abdomen; no gas in the colon; but we see a calcification in the right upper quadrant. This was thought by one observer to be a gallstone ileus, and some delay resulted.

The upright film taken a few hours later (Fig. 2) shows multiple small intestinal loops with gas, but none in the colon, and this is quite typical of small bowel obstruction. The calcification is now in the left lower quadrant, and it was thought the gallstone was passing. To make sure it was not a kidney stone an intravenous pyelogram was done; it was normal.

Lateral film shows the calcification to be anterior; so it rules out kidney involvement (Fig. 3). In looking at this in close detail you see it is not a stone. It has the appearance of an undissolved tablet in the intestinal tract, and it was a radiopaque pill.

Dr. Baker: The patient was operated upon, and an obstructing band was lysed. The patient had an episode of hypotension during surgery, and postoperative oliguria was a problem. The question was whether this was oliguria secondary to the stress of surgery or renal insufficiency following surgery. The patient did gradually increase his urine output to 550 cc. a day. The sixth postoperative day was marked by the appearance of a wound infection. The skin sutures were removed, the wound was opened, and foul-smelling material was obtained. Subsequently it was apparent that this was not the usual wound infection, and fairly large quantities of thin fluid drained out. On the tenth day, it was obviously not a primary wound infection but a fecal fistula. The patient began to drain copious amounts of green fluid, and the question was that of management. There was obvious mucosa in the base of the wound, and it was from this point that all the fluid issued. The wound was opened widely, and subsequently looked clean; large quantities of thin green material were issuing from the open portion of the bowel. Suction drains were placed on each side but not into the bowel, and it was felt that if we could not control it, further measures would be necessary. What would be your next step?

Dr. Stein: Let us go back for a minute and talk about a few generalities and then be specific. Dr. Grove has mentioned many of the underly-



Figure 2. On the upright film, taken a few hours later, the radiodensity is in the left lower quadrant. Note dilated loops of small bowel with air-fluid levels.

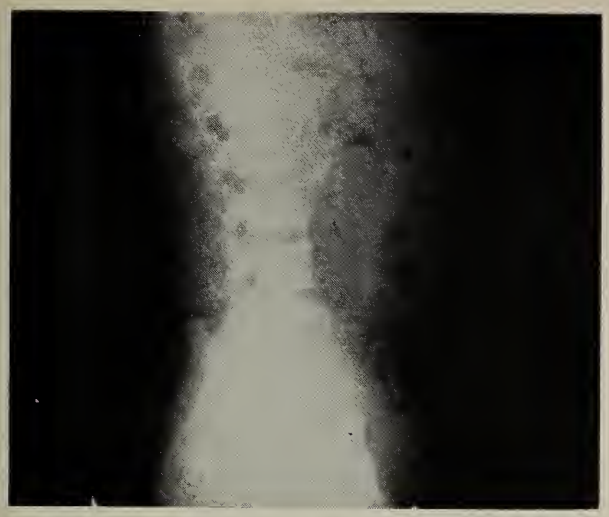


Figure 3. The lateral view of the intravenous pyelogram shows the radiodensity to be considerably anterior to the pelvis of the kidney.

ing causes. In general, postoperatively we could have a leaking anastomosis, a leaking enterotomy, a leaking duodenal stump, a stitch through the bowel, or a foreign body perforation such as from a toothpick or fish bone as a cause of a fistula. We can have ischemic or gangrenous bowel, as well. It may be due to a strangulated hernia, but that usually produces a spontaneous fistula through the hernia. We can have abscesses of various types, diverticulitis, appendicitis, or appendiceal abscess. Regional ileitis is another common cause for chronic fistula. Tuberculosis and actinomycosis are also causes of more chronic problems. Another possibility is a retained sponge or surgical instrument. Post-traumatic perforations with fistula are possible.

In terms of diagnosis there are several points we should consider. Abscess may not mean a fistula. Fecal-smelling pus may not be due to a fistula, but if gas comes out concomitantly it is a fair indication, although it is not 100 per cent. Food particles are a good indication that this is coming from the bowel.

Another factor that we must determine is how much is coming out. This will help determine whether or not we operate. We also want to have some idea of whether it is an incomplete or a complete fistula. We want to know if there is gas or stool in the rectum and if we put an indicator in by mouth or per fistula will it come out per rectum. Is an indicator going to go through, and is there a distal obstruction? For this purpose the use of radiopaque material as the indicator is very good. We can put it in by mouth or by fistula and see where it goes so we will have a better idea of the location of the fistula.

As for the principles of treatment, certainly in the high fistula, in one that is draining copiously and is starting to erode skin and superficial tissues, there will be a severe fluid, electrolyte, and nutritional problem. A duodenal fistula can be the worst, particularly if there is obstruction of the upper jejunum. This fistula may drain 1000 cc. or more a day, and this material may be returned to the jejunum via a jejunostomy feeding with great benefit. That may make the difference between life and death in duodenal fistula. Sometimes we have to replace as much as 6000 cc. a day, and we have to know what electrolytes to put in that fluid. This patient's electrolytes were very well handled and remained close to normal until just before he died, thus were not a therapeutic problem. I will not discuss nutrition because this was not the immediate problem, but does finally become the cause of death. He probably lost about 30 or more pounds through nutritional deficit.

What about the local care of the fistula? There are a number of things you can use, although none of them does much good. The best thing is to suck away the fluid. You remove as much fluid as possible and measure it. That will help protect the abdominal wall. The suction device may become blocked off; it has been suggested that daytime suction can be done nicely by the patient himself. That night he can be put on a Bradford frame and turned over so that the fluid can run off by itself. This may be a life saving measure by preventing erosion of the abdominal wall.

What are the aids to spontaneous closure? Many things have been written in detail in the literature, but they are actually of very little value. One method that may help is the passage of an intestinal tube by mouth. If you get a Miller-Abbott tube down, you can suck out all the material and later replace this fluid into the distal side of the fistula. This can be a good method of getting the patient in better condition and postponing surgery while he is in such a poor state. The conservative cure of the small bowel fistula is full of gadgets, most of which will not work.

A high fistula with copious drainage will require vigorous fluid replacement therapy. If the

amount of drainage does not start to decrease in four to six days, early surgical intervention probably will be necessary. If the fistula is lower and draining less, we will be less inclined to operate upon the patient, and it is more likely that that one will close spontaneously.

But what do we do if surgery is necessary? The incision is a hard one to make because you are going through an area that is completely eroded away and very difficult to close. You may have loops of bowel right in the bottom of the wound. I have occasionally made the incision in the opposite direction from the first incision. If it was vertical originally, make this next one transverse so that you are entering the abdominal cavity in a relatively clean area. On the other hand, where the two cross is the bad spot because it may be hard to close. Some will not close completely and will have to granulate for healing to occur.

What do you do when you get inside? Find the site of leak, resect it, and do an end-to-end anastomosis. This can be extremely difficult and that is why there are less advisable procedures being done, such as side-tracking procedures. It may be a life-saving measure, but it is asking for a good deal of postoperative trouble that may last for years. Blind fistulas continue to drain mucus and become infected and can cause abscess formation, further fistulas, and anemia and a good deal of abdominal distension. Blind loops, even where they are relatively short, fill up with foreign material, such as cherry pits, seeds or other inert material, which can cause chronic obstruction. If you can do the surgery without producing a blind loop, your patients will have better results.

Dr. Baker: Our problem here is still before us. Where in this man's course should we have operated upon him?

Dr. Grove: In retrospect, when one studies the electrolytes, one sees that there was a time when the patient was still relatively in balance, and surgery probably should have been undertaken at that time. However, it is extremely difficult to decide when to operate. It is always easy through the "retrospectoscope" to make the right decision. This was a small bowel obstruction presumably from a band. When there is a large area of gangrene, we all recognize it and quickly resect it; but when it is a band and the area of constriction is small, we are apt to be less careful about inspecting that area. On the antimesenteric border where the blood supply is less adequate, there may be a little blue area which can be overlooked. Such an area should always be looked for, and, if present, turned in with a few carefully placed sutures. I wonder if this patient's postoperative oliguria may not have been due to his not being in perfect balance at the time of surgery. I am not critical of this because sometimes one is forced to operate before rehydration can be accomplished. I think the preoperative preparation was adequate; considerable time elapsed prior to surgery.

Dr. Baker: We have a film to show where the obstruction was. A Foley bag was inserted into the proximal limb of the fistula to divert the flow, and this promptly resulted in the diameter of the fistula becoming three or four times its original size. We are convinced that this was not the way to manage such a problem because the bowel wall would not tolerate the pressure of the Foley bag. Consequently, the wound became digested so we promptly took the patient to the radiology department and this film was obtained.

Dr. Meszaros: In this film you see the catheter in the distal limb after the opaque substance has been injected into the fistula, which was in the ileum, perhaps in the distal 18 inches (Fig. 4). There was considerable irritability present.

Dr. Baker: It appeared that the enterotomy was in the jejunum, and not the site of leak. A



Figure 4. Radiopaque contrast material to show the level of the fistula. Its distal limb was injected, promptly filling the terminal ileum and cecum.

fistula secondary to an infarcted segment of bowel is most likely, just as Dr. Grove described. If you were to operate, what would be your approach in the face of a wide open wound?

Dr. Grove: I have tried not to operate on these people for a long time after the initial complication. We have seen quite a few; we have made some ourselves and some we have inherited. We have tried to keep these individuals in nutritional and electrolyte balance. These patients require a great deal of nursing care and attention; in fact, it has to be continuous. When the wound is clean and granulating and skin erosion is minimal, the repair can then be accomplished.

The thing that complicates his getting over the fistula is not how much he is losing but how much he is obstructed by ileus or peritonitis. If he can get over the initial insult of the fistula and then is able to eat, the problem is much simpler. I tend to favor conservative measures.

Dr. Baker: This patient had 14 units of blood between February 12 and 29, and innumerable units of plasma, without avail; he was not able to take oral feedings.

Dr. Manuel E. Lichtenstein: I feel strongly that earlier operation was indicated, probably five to seven days after the onset of the fistula. However, this patient was never a good risk, and the trauma of an extended procedure would have carried a prohibitive mortality. Very occasionally, some adhesions adjacent to the fistula can be freed and the fistula closed with some interrupted sutures. Even if the closure does not hold in its entirety, at least the fistula may be smaller. Certainly, under most circumstances, conservative management is best.

Dr. Baker: I should like to thank our participants for their illuminating and informative discussion.

Summary and conclusions

1. A fecal fistula of the small bowel may follow:
   a. Intentional creation of the fistula, which does not close spontaneously.
   b. Unintentional sequel to a surgical procedure, such as a leak of intestinal anastomosis, with or without intervening abscess formation.
   c. Inflammatory lesions of the bowel, with abscess formation (Meckel's diverticulitis, regional enteritis, appendicitis).
   d. Inflammatory lesions of the bowel, without abscess formation (regional enteritis. tuberculous enteritis, abdominal actinomycosis).
   e. Penetrating trauma (gunshot, stab wound).
2. Use of drains to the area in which leak from the bowel is a possibility may mean the difference between survival and death; a fistula to the outside is far better than leak followed by peritonitis and death.
3. Fecal fistula will close spontaneously in about 50 percent of cases; those that do *not* close spontaneously may involve:
   a. Obstruction distal to the fistula.
   b. Lining of the fistulous tract with mucous membrane which meets skin.
   c. Presence of a foreign body (bullet, infected silk suture, fecalith, etc.).
   d. Inadequately drained abscess cavity.
   e. Inflammatory lesion of the bowel.
   f. Malignancy.
4. If a fecal fistula is to be treated properly, it *must* be determined that no distal obstruction exists. X-rays with contrast media are utilized to ascertain this.
5. The advent of a high, small intestinal fistula is quickly followed by:
   (1) Severe fluid and electrolyte loss;
   (2) Digestion of skin and fascia at fistula.
   The severity of these conditions is determined by the level and the size of the fistula, assuming no distal obstruction exists.
6. Treatment of the fecal fistula may be expectant or surgical. Conservative management is not indicated after two to three months, perhaps less, as fistulas of long-standing will not ordinarily close spontaneously.
7. Surgical treatment varies with the cause and the location of the fistula. It may involve:
   a. Excision of the tract and closure of the intestinal defect.
   b. Excision of the tract and resection of the portion of involved bowel (especially applicable if the defect is on the mesenteric side of the bowel).
   c. Side-to-side enteroenterostomy, by-passing the fistula (partial diversion).
   d. Transection of the bowel proximal to the fistula, closure of the distal end, and end-to-side enteroenterostomy (complete diversion).

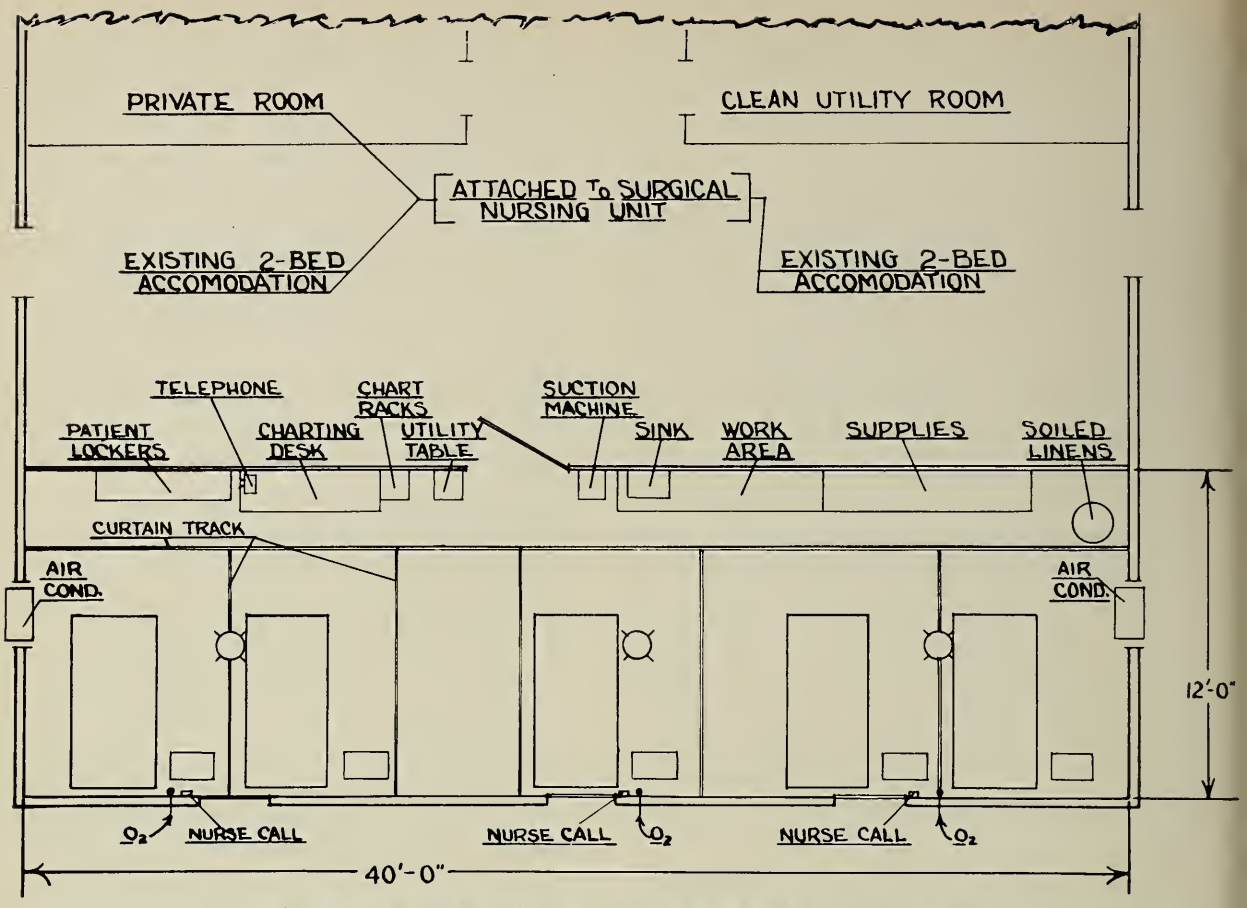


Figure 1. Layout showing location of special care unit in hospital.

A Special Care Unit In a Community General Hospital

WILLIAM K. STEPHAN, M.D., and C. ELLIOTT BELL, M.D., *Decatur*

Small opportunities are often the beginning of great enterprises. The special care unit at the Decatur & Macon County Hospital is a convincing testimonial to the truth of this adage. This unit began as a modest 90-day pilot study on Nov. 20, 1958. After eighteen months of continuous operation it is hailed as a truly significant advance in the care of critically ill patients.

Problems in patient care at the Decatur & Macon County Hospital are common in all community hospitals. Emergency rooms are too busy and usually too small to permit several hours' intensive care of severely injured people. Every physician has been frustrated in attempting to care for a desperately ill patient in a room or crowded ward in a regular nursing unit. The nurses, aides, and orderlies are fully occupied with regular assignments. To meet a crisis with one patient must mean less than optimal care, for a time, for many others.

The recovery room, now recognized as a necessity in all progressive hospitals, can provide excellent care for each day's surgical patients. But what happens to the more seriously ill patients after the recovery room closes? The need for adequate care for all patients at all times is obvious to every physician, nurse, and administrator.

The simple and direct solution to this problem is a special care unit.

Presented before the Section of Anesthesiology, Illinois State Medical Society Annual Meeting, May 24, 1960.



Figure 2. Portable cabinets, window air conditioner, and oxygen outlets installed in special care unit at Decatur & Macon County Hospital.

Development

A successful special care unit must begin with the nucleus of individuals convinced of its need and determined to prove its potential. The nucleus must be the director of nurses, the administrator, and several physicians. At the Decatur & Macon County Hospital the nursing service and Education Committee, augmented by interested representatives from administration, general practice, surgery, pediatrics, and anesthesiology, held the first organizational meeting in 1958. Three basic ideas were crystallized at this conference: (1) start with a small unit; (2) use top quality personnel; (3) include only bare necessities.

Physical specifications. A five bed ward, 12 by 40 feet, was selected for the pilot study, with the future possibility of enlarging the unit to include two adjacent two-bed wards. (Fig. 1). Several portable cabinets and a small nurse's desk were added. Window air conditioners and extra outlets in the oxygen piping system were installed. (Fig. 2).

Personnel. The staff of the special care unit is small — only one registered nurse and one licensed practical nurse on each shift.*

During peak loads, or when one patient requires the nurse's undivided attention, additional nursing help is promptly supplied by the assistant nursing supervisor. Similarly, when the licensed practical nurse or nurse's aide is not needed in the unit, she is temporarily assigned to work on a nearby general nursing unit. Such flexibility has assured the special care unit of optimal personnel coverage in all situations, and the regularly assigned personnel is fully utilized at all times.

Efficient distribution services from ancillary departments to all nursing units keep nursing personnel at their stations — a significant factor in the success of the special care unit.

TABLE 1. Supplies Available in the Special Care Unit.

Fibrinogen	Na lactate (1 molar)
Albumin	Na thiopental
Plasma	Succinylcholine chloride
A plasma expander	d-tubocurarine
30% ethanol (for vapor inhalations)	50% dextrose/water
10% calcium chloride	Cedilanid

Supplies. The supply of drugs and equipment is designed to meet all crises. Agents not usually in stock in other units are available in the special care unit (Table 1). In addition, special equipment is maintained in the special care unit (Table 2).

Admitting policies

It is axiomatic that any patient who has a chance for recovery under extraordinary care is a candidate for admission to the unit. In addition, emergency surgical patients whose operations are performed when the recovery room is closed are routinely admitted to the special care

TABLE 2. Surgical and Resuscitation Equipment for Special Care Unit.

Emergency thoracotomy tray	Lumbar puncture tray
Thoracentesis tray and underwater seal drainage apparatus	Venous pressure tray
Minor surgical tray (with intravenous catheters)	Sterile gloves and gowns
	Portable spotlight (A.C. and/or battery)
	Sharp disposable needles
Laryngoscope with variety of blades	
Endotracheal tubes and adapters	
Oral and nasal airways	
Non-rebreathing valve (Fink modification) and bag or Ambu Pneumonator	
Tracheotomy trays (Sheldon tracheotome)	
Portable suction machine	

**A few nurses' aides with unusual temperament, interest, and ability have been especially trained to work effectively in place of the licensed practical nurse in the special care unit.*

unit for postanesthetic recovery. Only three types of patients are excluded: (1) hopeless terminal cases; (2) isolation cases; (3) pure psychotics who are either destructive or agitated.

Since the special care unit was devised to provide the finest possible nursing and medical care, the usual lines of jurisdiction between physicians and nurses are sometimes indefinite. The delicate problem of assigning authority for admission and discharge is potentially a "two-headed tiger." The current policy of the Decatur & Macon County Hospital authorizes the Nursing Supervisor to transfer or admit to the special care unit any patient whose condition requires close supervision and intensive therapy. The attending physician must approve the transfer, and he may request direct admission to the unit for a patient by discussing the case with the nursing supervisor. Thus the usual delay in clearing patients through nonprofessional personnel in the admitting office is avoided. The nursing service determines when a patient in the unit may be adequately handled on a regular nursing unit, and the physician is asked to discharge the patient from the special care unit.

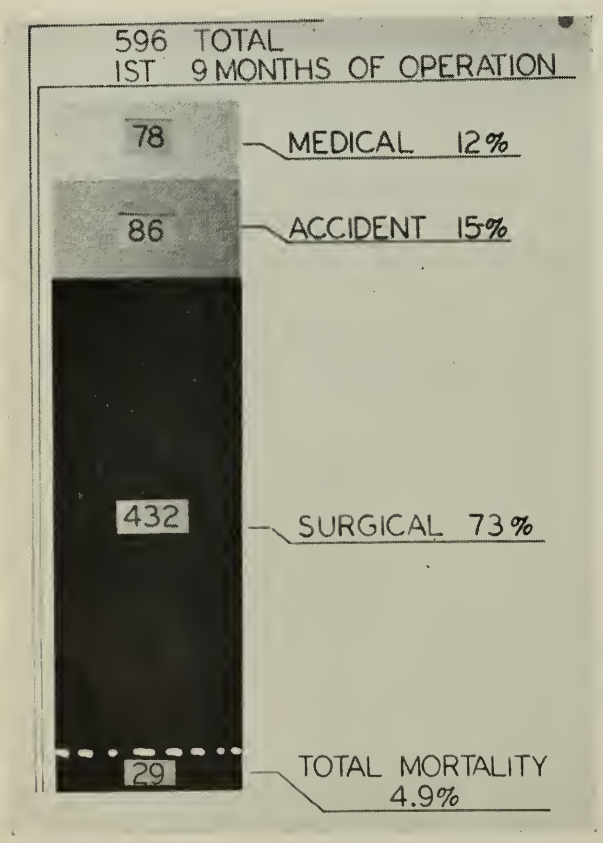


Figure 3. Utilization of special care unit.

In over eighteen months no one has "twisted the tiger's tail" and challenged this bilateral authority. Controversies, if they arise, will be referred to the chief of service involved.

Operational regulations

In such a small unit the patients cannot be segregated according to age, sex, or race, except by curtains mounted on ceiling rollers. Anticipated objections have not materialized. When a patient is well enough to complain of his surroundings, he no longer requires special care.

One adult member of the patient's family may visit at any time, day or night. Children are excluded except in life-or-death situations.

Flowers and gifts are not allowed in the unit. When received, they are displayed to the patient, and then the family is asked to take them.

Facilities for entertainment are not permitted. Radios, television sets, telephones, and smoking are specifically prohibited. All of these regulations are consistent with the basic policy of maximum care and basic necessities.

Public relations

A carefully planned public relations program is a requirement for success of the special care unit. Prior to the opening of our unit, the entire professional and nursing staffs were informed in detail of the policies and regulations which would govern it.

Before admission to the unit each patient and his family are fully advised of the purpose, function, and regulation of the unit. Close contact and frequent communications between families and the professional and nursing staffs have greatly enhanced good will. The nursing supervisor is specifically responsible for communications with the family, but frequently the physician and house officers add important words of encouragement and explanation.

Utilization

Our unit has been a busy place since its inception (Fig. 3). In an average month about 65 patients are admitted; about 73 per cent are surgical, 15 per cent are medical, and 12 per cent are accident cases.*

**Obstetrical cases requiring special care are handled in the intensive therapy and recovery room unit of the department of obstetrics, which is operated on a 24-hour basis.*

About one third of the patients stay in the special care unit six hours or less (Fig. 4). An additional one third is discharged after 6 to 24 hours. The majority of these patients are those admitted for recovery from anesthesia following emergency operations. Although this group of patients represents "bread and butter" for the unit, one should not conclude that the special care unit is just another recovery room. Approximately 10 per cent of the patients remain in the special care unit more than three days.

Statistical evaluation by the hospital comptroller indicated the unit was utilized to 70 per cent capacity throughout the first nine months of its operation. Occupancy throughout the entire general hospital during this same period was over 85 per cent.

The mortality rate in the special care unit has been 4.9 per cent. When one considers the critical condition of many patients in the unit, this rate is surprisingly low. The death rate throughout the entire hospital has been approximately 1.6 per cent.

The School of Nursing has effectively used the special care unit because if its excellent opportunities for clinical demonstration of the nursing arts in their finest applications.

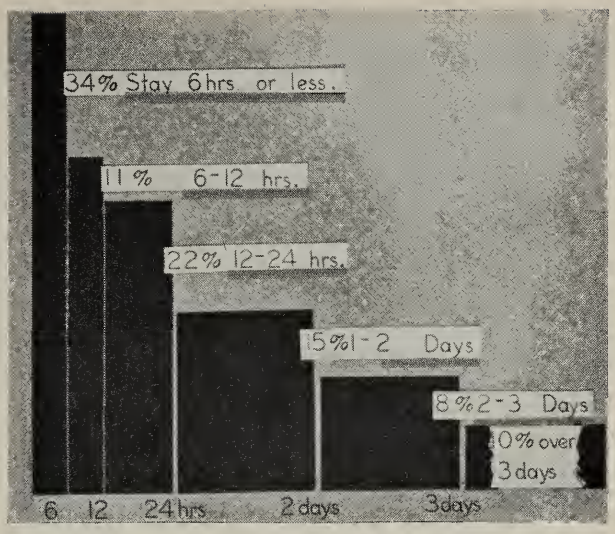


Figure 4. Duration of stay in special care unit.

Economics

The Unit has functioned exactly as planned, that is, it has been optimally staffed and financially independent. The rates charged for services are as follows: A patient admitted for six hours or less is charged $8.25. The basic minimum for regular room is $17.50, and the additional charge for special care is $16.50 per day, a total of $34 per day. This figure may seem relatively high, but it is not. On the contrary, it represents a substantial saving to the patient, since private duty nurses, if available, charge $48 for twenty-four-hour service in addition to the room charge, a total of at least $65.50 daily. It is encouraging to note that Blue Cross has fully approved the charges for this special care unit.

Critique

There are no immediate plans to increase the size of the special care unit at our hospital. The optimal size of the unit should be 16 or 18 feet wide instead of the current 12 feet so that more equipment cabinets might be installed, and carts and beds moved with greater ease.

This unit was started on a small scale for specific reasons. Too large a unit poses greater disadvantages than one that is too small. First, more beds might tend to encourage the admission of undesirable cases; second, the discharge of cases might be delayed unnecessarily; third, more patients in the unit would require a larger staff and thus increase costs; and fourth, nursing care for the patients who need it most might be less than optimal.

The most apparent deficiency in the special care unit is the absence of isolation facilities. Serious doubt exists in many minds about the advisability of incorporating in the special care unit an area for the care of contaminated or contagious cases. Isolation techniques can seldom be maintained in emergency situations. Cross-contamination to other desperately ill patients is a sobering consideration. Therefore, an isolation facility is not being planned.

A more permanent type of partitioning may be desirable so that noisy patients and those with malodorous conditions may be separated from their neighbors. This is a rather serious consideration, particularly for medical patients, and improvements are being considered.

In further critical appraisal, one recognizes that the location of our unit might be improved if it were immediately adjacent to the emergency rooms, the operating suite, and the internes' call room. On the other hand, its proximity to a general nursing unit is a desirable feature because additional help can be recruited in a matter of seconds in emergency situations.

Developing new units

If you have been sufficiently innoculated with our enthusiasm for the special care unit and should decide to establish one in your hospital or plan to incorporate one in a new hospital, then a few suggestions are in order.

First, what are the specific needs for your institution? Do you need a relatively larger or perhaps a smaller unit than the one which serves the 360 beds in the Decatur & Macon County Hospital? Do you maintain an active neurosurgical service? Are many trauma cases referred to your hospital? If so, more beds may be needed than we have indicated. Conversely, if your hospital has an elite clientele with mostly elective problems, a relatively smaller unit may suffice.

Second, visit some special care units. Several have been established in large metropolitan teaching centers, and each of you is certainly welcome to evaluate our unit in Decatur.

Third, read some of the comprehensive literature on this subject.

Fourth, after researching the needs and plans for your unit, sell the idea of a special care unit to your administrator, director of nurses, and your medical colleagues before your project begins. Finally, start with a small unit, and staff it with your very best nurses.

Summary

The first special care unit in a community general hospital in Illinois has been functioning since November, 1958. Its basic purpose is to concentrate into one small area maximum care with the best facilities for critically ill patients, at a reasonable price.

Any patient who has a chance of recovering with extraordinary care is a candidate for admission. The unit serves also as a recovery room for emergency surgical patients. Only hopeless terminal cases, isolation cases, and agitated psychiatric patients are excluded.

The unit is staffed 24 hours a day with one registered nurse and one licensed practical nurse or nurses' aide, each of the highest quality.

A ward with space for five beds and two carts has been utilized to more than 70 per cent of capacity. Two thirds of the patients remain in the unit 24 hours or less.

The authors recommend the establishment of special care units in other community hospitals. No other innovation in total care can so dramatically reduce mortality and morbidity. The unit further provides:

(a.) Immediate availability of complete emergency armamentarium;
(b.) Optimum utilization of all nursing personnel;
(c.) Excellent teaching opportunities;
(d.) A potent instrument for improving public relations, and
(e.) Twenty-four hour postanesthetic recovery facility.

You will be amazed that a project so small can accomplish so much for so many critically ill patients.

* * *

In the ten months since this paper was presented, the special care unit has been enlarged. By including in the unit an adjacent four-bed ward plus a private room and an examination-utility room (see Fig. 1), the special care unit can now accommodate ten bed patients and three patients on carts. The staff has been increased to two registered nurses and two practical nurses. Central heating-air conditioning units with individual thermostats have been installed as well as two additional sinks. Admitting, operational, and financial policies are unchanged. Utilization of the enlarged unit has been approximately 65 per cent of capacity. Inclusion of a private room has been especially beneficial. Acceptance by the laicty and the profession continues to be enthusiastic.

A single conversation across the table with a wise man is worth a month's study of books.
—*Chinese Proverb*

Alcoholism and Food Allergy

Herbert E. Karolus, M.D., *Dwight*

It has been generally observed that the fundamental difference between the casual or social drinker and the alcoholic is the factor of neurotic compulsion—the inability of the alcoholic to "take it or leave it." Another significant difference relates to the peculiar changes in the personality and behavior suffered by the drinking alcoholic. Since such factors are not evidenced until after the first drink, it is tempting to speculate that perhaps some substance in the drink itself causes the victim's "sensitivity to liquor," a phrase often used in describing alcoholism.

Experienced therapists have also observed a peculiar phenomenon, the so-called "dry-drunk," which occurs as a symptom with some abstaining alcoholics. The patient on a dry-drunk manifests behavior patterns and personality changes similar to those he shows when drinking. Might such manifestation be due to reaction to allergens in his food similar to those found in the alcoholic beverages he drinks? An almost universal action of the alcoholic in attempting to solve his problem is to change his choice of beverage from, say, gin to whisky or from whisky to vodka or brandy. Surprisingly enough, this seems often to work briefly.

The rationale for believing that the alcoholic is, indeed, peculiarly sensitive to the beverages he imbibes, involves the basic principles of a biochemical reaction within the human body, with its effect on the nervous system. Once the alcoholic starts to drink, he reacts in much the same uncontrollable manner as the hay-fever victim, who sneezes uncontrollably from contact with certain pollens, or the food-sensitive person who develops gastrointestinal symptoms, purpura, or urticaria. The analogy is further borne out by a recently published comparison of alcoholism with obesity and compulsive eating[1].

To explore this problem, a research project involving 442 alcoholics was started in November, 1958, at the Keeley Institute.

From the Keeley Institute, Dwight.

Method of study

Food sensitivity. Acting on the premise that sensitivity to some foods might potentiate or complicate the problem of alcoholism, we thought it reasonable to explore, by standard diagnostic procedures, the qualitative and quantitave allergic reactions of a test group of alcoholics.

In earlier experiments, patients who had previously been diagnosed as alcoholics had voluntarily contributed valuable clinical information. They were put on a fasting diet for from three to five days, after which daily test meals were given. A whole meal of only one substance, such as corn, rice, or wheat, was given once daily and the patient closely observed for objective symptoms—changes in pulse rate, temperature, respiration, mannerisms, speech, behavior, and the like. In some patients there was increased flushing, fidgeting, excitement, or unsteadiness of gait. In some, a complete change of personality took place; serenity was replaced by belligerence; a drink was first requested, then demanded; and it was reasonable to suppose that, had alcohol been accessible, the patient would have begun a new drinking cycle.

On the assumption that such manifestations might well be a direct reaction to food allergies, with concomitant neurologic and psychologic effect, it was considered that the alcoholic might be desensitized, as with other allergy victims. As a first step, skin tests were made on 442 alcoholics. Allergens included apple, barley, blackberry, corn, date, fig, grape, hops, juniper, malt, oats, plum, rice, rye, sugar cane, tapicoca, wheat, yeast, and oak. Coffee and tobacco were also included, for while these are not ingredients of alcoholic beverages, their addictive qualities are felt to complicate alcohol addiction. While we are aware that many allergists disapprove of skin tests for foods, we considered this the method of choice because of the time element involved.

Further test meals. In the more recent series of test meals, twenty patients volunteered to submit to testing with the foods to which they had

reacted in the skin tests. Of these, 14 were tested for one food and six for two foods. Test meals of rice, grape, and rye were selected as interfering least with the general diet; additionally, one patient was tested for apple and one for wheat. Patients were instructed to abstain, for five days in advance of the test meals, from the foods on which they were to be tested, and all medication was withheld for 36 hours before the tests.

Test meals were served at 8 a.m., the last previous meal having been eaten at 5 p.m. the preceding day. Test individuals were under constant observation from 8 a.m. to 10 a.m. following the meal. They were checked again at noon, at 5 p.m., at 7:30 p.m., and at 7:30 a.m. the day following. Pulse rates were recorded every 15 minutes and temperatures at half-hour intervals.

Preliminary results

All 442 patients given skin tests showed at least one reaction. The average was seven reactions per patient. Two patients exhibited sensitivity to 13 allergens. The most frequently positive tests were for rye (301) and for wheat (239). Fewest reactions were to dates (58) and sugar cane (80).

Tested patients were advised to take weekly desensitization treatments from their family physicians. Some 200 complied; the others can serve as a control group for later evaluation of results. We believe that not only may such treatments help the alcoholic physiologically but also that the compulsion to drink may be lessened through the psychotherapeutic value of regularly continued constructive effort by the patient. While sufficient time has not yet elapsed for statistical conclusions on results, there have been encouraging reports from individual patients.

Following test meals 20 specific reactions were noted, the composite reactions determining the plus range. For skin tests, this average equaled 2.5 plus, whereas for meal tests the average equaled 2 plus. Two of the negative test meals, of grape, were 1 plus; in skin tests grape was 1 to 2 plus. The other 5 negatives in test meals were with rye.

Test meals confirmed 69 per cent of skin tests. Recognizing that some skin tests showed only a slight reaction (1 plus or 1 to 2 plus) it may be reasonable to suppose that if only the 3-plus or 4-plus skin reactors had been selected for test meals, the ratio of test-meal reactions to skin tests would have been higher.

Conclusions

While it is too early to draw any significant conclusions from the work so far done, the findings are at least interesting enough to encourage further studies. These are now under way and will be reported at a later date.

Summary

Examination of 442 alcoholics at the Keeley Institute has led to support of the belief that there is a demonstrable relationship between alcoholism and food allergies. Skin allergy tests followed by test meals were employed to explore these relationships, while desensitization through weekly injections of allergenic extracts of offending substances appears to be offering both physiologic and psychologic therapy. Further investigations are in progress.

Appreciation is expressed by the author to George Marsh, of Hollister-Stier Laboratories, Chicago, for valuable assistance in providing allergen test materials and for assisting with testing and interpretations, and to C. S. Boruff, Ph.D., of Hiram Walker & Sons, Inc., Peoria, for defining materials used in alcoholic beverages and for consultation on allergy data.

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Sometimes one pays most for the things one gets for nothing.—*Albert Einstein*

CASE REPORT

Membranous Dysmenorrhea

A Case Report

Joseph P. Miranti, M.D., *Greenup;* John F. Hubbard, M.D., *Mattoon;*
and K. J. Costich, *Oak Park*

The purpose of this paper is to report a case of membranous dysmenorrhea with a six year follow-up which has been treated successfully by relatively simple but conservative means.

The case is that of a 40 year old, well developed, well nourished white female who was seen for the first time on Dec. 8, 1953, complaining of an exuding odoriferous, purulent discharge from the vagina. She stated that she had had menstrual periods with passing of solid particles ever since she was 15 years old. Her first menstrual period was at the age of 14. These were regular and occurred about every 26 to 30 days. During the menstrual period, especially the first day, there was extreme, incapacitating cramping. She had had one pregnancy carried to term 19 years prior to being first examined by one of us (J. M.).

Physical examination was essentially negative except for the fact that protruding from the external cervical os was a strip of avascular necrotic tissue about 2 mm. in diameter extending back through the os, which constricted the tissue. In our inexperience with a case of this sort, we considered that the patient had had a miscarriage with incomplete separation and partial retention of secundines. She emphatically denied intercourse over a period of at least two years, having been separated from her husband for that time. Surrounding the necrotic tissue protruding from the os was copius, yellowish-green, purulent material.

The patient was put on antibiotics, and a douche of 2 tablespoons white distilled vinegar to 1 quart warm water was prescribed. Two days later the patient brought in a specimen from her vagina which measured about 6 cm. x 1.5 cm. x 0.5 cm. On examination the cervical os was normally patent, and the purulent material was greatly lessened in amount.

Vaginal smear revealed no gonicocci and the Kahn was negative. Cultures for acid-fast bacilli were negative. The Widal test revealed a positive titer in dilution of 1:160 for typhus. Subsequent follow-up attempts to duplicate this positive agglutination were unsuccessful. Red blood cells and urinalysis were within normal limits.

A diagnostic D and C performed on December 18 revealed only secretory endometrium. Subsequent months of mild therapy with very conservative means were accompanied by the typical incapacitating cramping and the passage each month of a complete cast of the uterus following which there was abrupt cessation of all symptoms. The patient led a normal life until the onset of her next period.

Gross pathology showed a friable blood-clot-like cast of the cavity of the uterus as in figure 1 (top). The microsection showed blood with sloughed off endometrial tissue. There was no organization of the clot or attempt at tissue formation. After four months' time it was decided logical to use a Streptokinase®-Streptodornase® douche in the attempt to break the cycle of formation of this necrotic membranous cast. Accordingly, the patient was instructed to take a douche consisting of 100,000 units of Streptokinase and 25,000 units of Streptodornase dissolved in one quart of water. She was instructed to use this douche on Tuesday and Friday nights at bedtime and the rest of the week she was to use the white vinegar douche. The period following the first use of the Varidase® douche was accompanied by the usual cramping, but the cast did not pass entire. It seemed subjectively to the patient that the usual cast was fragmented, and within three months the patient was reporting a marked relief of cramping at the menstrual period. After four months the patient reported no cramping and a normal menstrual period of five days with no clots and no cast. The patient used the Varidase douche twice a week from August, 1954, until February, 1955. After that time she reported that, while she continued douching with the white vinegar, at times she did not use the special douche since there was neither cramping nor membrane at her periods. The patient was seen in follow-up on March 13. 1956. At this time a pelvic examination showed absence of clot (or membrane) and an otherwise normal genital tract. The patient reported normal periods every twenty-eight to thirty days with the passage of no more membrane.



Figure 1. Comparative sizes of casts of uterus. TOP: Cast of uterus of a patient with three months spontaneous abortion, for comparison only. CENTER: Original cast passed by patient with membraneous dysmenorrhea before treatment in December, 1953. BOTTOM: Cast passed by patient August 8, 1959, on follow-up of treatment.

She continues to report herself menstruating regularly and with only mild cramping which she can tolerate well. On July 8, 1959, she reported that on only three occasions has anything approaching a membrane been passed, but it has been so small as to cause no discomfort. She continues to use only her vinegar douche. Representative pictures with dates will help the reader assess results in this case and realize why she is now menstruating symptom free (Fig. 1).

Discussion

It would appear to us that the use of an enzyme that will attack dead tissue is a logical approach to the therapeutic problem embodied in each case of membranous dysmenorrhea.

A case is sited in which a patient was rendered asymptomatic after a six year follow-up following the use of Varidase douches twice weekly for six months.

It would seem that once having broken the cycle of membrane formation in this case of membranous dysmenorrhea by the use of Streptokinase and Streptodornase douche, this patient's menstrual cycle was restored to normal.

To our knowledge successful treatment of severe membranous dysmenorrhea has never before been reported with so conservative means.

Dr. Tom Spies

Pioneer Medical Nutritionist

James R. Wilson, M.D., *Winnetka*

One of the remarkable things about being a working medical nutritionist in the mid-twentieth century is the opportunity to know personally the discoverers, the adventurers, the heroes, the pioneers whose names will live forever as the dedicated men and women who have pushed forward the frontiers of nutritional knowledge. I have found it as exciting to know E. V. McCollum, Minot and Murphy, James S. McLester; Paul Cannon, William Darby, John Youmans, Conrad Elvehjem, and the many others of you who have ventured forth into the scientific unknown, as it would have been to have been on speaking terms with Christopher Columbus, Magellan, Sir Francis Drake, Father Marquette, and William Penn, all at the same time.

I wish to pay tribute to the career of one of these pioneers. When first we met, I am sure that neither of us had the slightest idea that our life work would revolve around food and nutrition. In fact, he had not as yet won the right to place those two hard-earned letters M.D. after his name, and my own M.D. was so new that I wore it like a neon sign. He was in that year of 1924 a beginning medical student at Harvard, while I was the youngest, and I might add the lowest paid, member of the faculty of that great institution.

By the summer of 1926 he had progressed to the professional estate that made it possible for him to serve as the physician's aide on the *S. S. George Washington,* shuttling between New York and Southampton, England; while I had by great economy saved enough dollars to be a third-class passenger on that same boat. Quite unexpectedly a few months ago among the mementos in our attic I found a sheet of *S. S. George Washington* stationery. That piece of paper had been signed by all the members of our merry shipboard party. The final name on the list is *Tom Spies, Ravenna, Texas.*

Our paths were to cross and recross, over and over again, for 36 years.

Never shall I forget a day I spent with Tom Spies not long after the publication of the book, "Vitamin B_1 and Its Use in Medicine," which he coauthored with Robert E. Williams. A survey of nutrition research centers took me to Tom's personal headquarters, the Nutrition Clinic of the Hillman Hospital, Birmingham, Ala. (which, I might add, has been a part of Northwestern University since 1950). What a day it was! It started early when I accepted Dr. Spies' invitation to accompany him on calls to his patients in the hill country. I listened while he imparted his enthusiasm for good nutrition to those people to whom poor nutrition had brought disaster.

At one mountain shack where we stopped, Tom promised me that I would hear a family speaking the Elizabethan English that their isolation had let them retain. This was one disappointment of my day, for we found only patient Betty at home, and she had a harelip and couldn't talk at all!

During the afternoon I shared with Tom the examination of his patients in the clinic, a tornado struck Birmingham. It was within hearing distance, but since it in no way distracted Tom Spies from concentration upon nutritional deficiency diseases, I had to act as though tornadoes were routine in my life too.

Tom Spies' death on Feb. 28, 1960, in the Memorial Center for Cancer and Allied Diseases has taken from our midst a dynamic, colorful, dedicated, and sometimes controversial pioneer of nutrition science, and to quote from a recent

Presented at the Joint Conference on Nutrition, Normal, Ill., Oct. 8, 1960.

Member, Illinois State Medical Society Committee on Nutrition, and Illinois Nutrition Committee.

The View Box

Franz Gampl, M.D.
Chicago

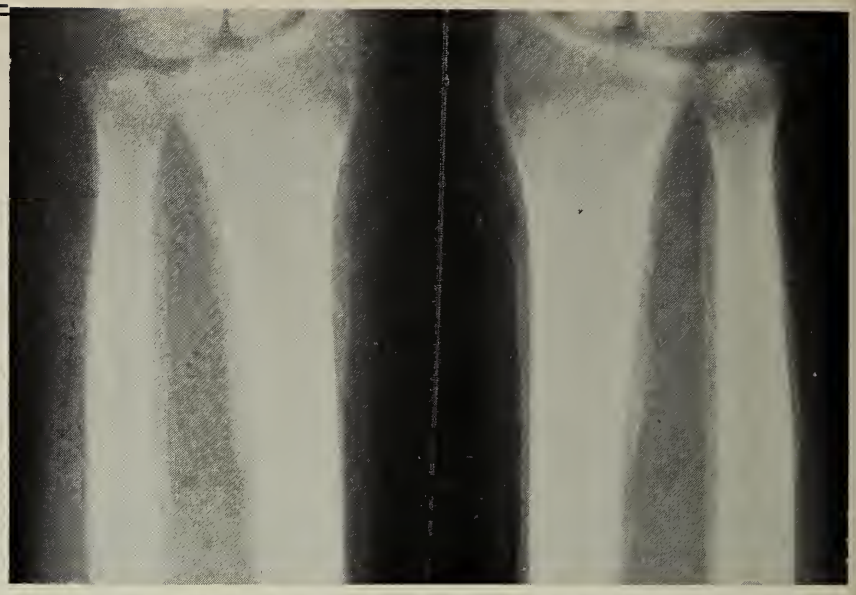


Figure 1. Roentogenogram showing both wrists and forearms.

A 40 year old foundry worker was admitted to the hospital with complaints of progressive and gnawing pain in his wrists and legs. He also gave a history of precordial pain, night sweats, and cough productive of some white sputum in the morning. He denied hemoptysis. He was well until three weeks prior to admission.

The pain in his extremities was relieved by salicylates. The physical examination was noncontributory except for slight pitting edema of both ankles, pretibial tenderness, and slight swelling of his wrists. The fingers were not clubbed. The laboratory data showed a moderate hypochromic anemia and a leukocytosis.

What is your diagnosis:

Chronic osteomyelitis
Paget's disease
Osteoarthropathy
Rheumatoid arthritis

(*continued on page* 159)

Tom Spies (*continued from page* 155)

letter from Dr. Robert E. Williams, " . . . a thoroughly unselfish person." We are the poorer for our loss.

Perhaps the message Dr. Tom Spies would want us to have from his 57 years of life can be summarized in his own words, when in 1957 he accepted the Distinguished Service Medal awarded by the American Medical Association for his outstanding work in the field of nutrition, especially his study of the dietary requirements for the preservation of tissue integrity, whereby premature aging can be prevented:

" . . . to summarize, there is hope for some that are considered hopeless for we have learned that even the cells of the young and of the elderly cannot be said medically to be finished. Often they have been pushed into submission, partial or complete, but if given another chance by application of the newer knowledge of nutrition, they will again muster their strength and bounce back. It is characteristic of the cells of our bodies never to give up. Over and over again we have seen new remedies come to our aid and have observed the affected cells to fight back stubbornly and successfully. What does this prove? I feel it proves that when we know enough about nutrition and all its proper uses, disease will have less success in shortening our prime of life."

MEDICINE IN THE OUT-OF-DOORS



INSULATED CLOTHING

JULIUS M. KOWALSKI, M.D., *Princeton*

Cold weather clothing is becoming increasingly abundant and varied, and some claims made for it are, at times, confusing or outright contradictory. No clothing can produce heat, only conserve it — retard its dissipation from the body. Dead air is the most effective insulator against body heat loss, and moisture is the stealthy robber of it.

Through the years wool was peerless for one who had to brave winter's icy blasts. Sheepskin-lined clothes and boots were worn by many and served them well early in World War II. For general all-purpose outdoor wear it still holds a commanding position. It is relatively inexpensive, comes in a wide assortment of weaves, finishes and weights, is readily tailored to any need, and when dry, has excellent heat-retaining properties because of its resilient fibers and trapped air spaces. But several shortcomings are apparent. Outer woollen garments invariably need professional dry cleaning services and when soiled frequently, this cost must be considered. Wool is subject to almost constant insect predation which necessitates special protection and storage. Careful laundering is necessary to minimize shrinkage or misshaping; this will certainly occur from repeated washings. It will not endure steady, abrasive use, and it is not wind or water repellent. It dries slowly, as every camper will attest; there is nothing wetter than a pair of soggy woolen socks. But wool is still the trusty standby of the outdoorsman, be he farmer, utility man, or hunter.

For snuggling warmth, nothing can equal Grandma's goose down quilt. It was re-made and patched and handed down from one generation to the next. For good reason. No man-made substance even now can be compared to it for lightness and insulating qualities. In our relentless quest for this valuable commodity, several bird species have been driven to extinction. Waterfowl down is best for protection in zero and below temperatures, be it in outer garments or sleeping robes. It is very light, dries readily, and is the most compressible of the insulating materials. It can be laundered as well as dry cleaned, but it is subject to insect attack, though to a lesser degree than wool. It is pervious to wind and moisture.

The Air Force has under study currently down-filled arctic survival suits which are claimed to protect a man at 50° below zero. This is a hooded coat extending to the feet with draw strings to convert it into a "sleeper," or it can be shortened, using snaps, for walking. Down-filled boots with leather soles and matching mitts and a windbreaker parka and pants complete the outfit, all of which can be packed into a shoe-box-size container and weighs about seven pounds. These suits are available to the public in limited quantities. This demonstrates the versatility of down — a far cry from the heavy, multilayered woolens and pile-lined parkas of the flight personnel on the first Polar missions. Thus clothed, an uninjured man could survive for thirty days on the Arctic ice pack.

Outdoor gear has improved remarkably in the last fifteen years with the development of synthetic fibers. These are known under trade names of Acrilan, Dacron, and polyester fibers. Their insulating properties are good, wearing qualities better than wool; they launder and dry well, are not affected by insects, and are virtually indestructible. They, like wool and down, need an outer covering to repel moisture and wind. Presently they are used in insulated underwear, coats and pants, and sleeping robes. For rugged, con-

tinuous outdoor wear they have no equal, despite a slight weight increase over down.

None of the above fibers and fabrics are fully protective in themselves unless covered by a windbreaker. A waterproof parka worn over this type of clothing is best. On a calm day it can be removed to prevent excessive perspiration and allow ventilation. But reckon with the wind! Cold on a windless day is tolerable even when the thermometer reads zero, if one remains active. However, light and variable winds — two to five miles per hour — begin to waft away the covering of warm air that surrounds the body, and the discomfort increases with the wind velocity. Witness the numbed spectators leaving a football stadium on a November Saturday afternoon. Arctic gear should more properly be the order of the day. Circulatory damage to the extremities can follow quickly, ending in death due to exposure. The successful British assault on Mt. Everest was due in large measure to development of windproof fabric impervious to winds of 100 miles per hour. Such winds are an almost daily occurrence above 25,000 feet, and the temperature is constantly below zero.

Though cold tolerance depends on adaptation and psychological characteristics, we cannot withstand severe cold accompanied by incessant wind. Should such conditions arise, seek a shelter, and soon. Only the bison will face the storm; we, like our cattle, must present our backs to it. Protect the head and neck, wrists and ankles. If these three areas of the body are adequately protected, the remainder of the body will be comfortable.

When properly clothed, the rigors of winter hold no fears for us. Many cold weather activities formerly enjoyed only by a certain sub-species are now available to the many. The renaissance is here — thanks to better utilization of well known fibers, development of new ones, and an understanding of cold phenomena.

Eating—for the space man

How will the astronaut eat? What will he eat? These are problems of a practical nature. The answer to the first question is comparatively simple. The environment of the cabin will permit facile intake of food and drink except during the period of launch and during re-entry into the earth's atmosphere. However, weightlessness, in conjunction with many necessary protective measures, would make the conventional handling and eating of food somewhat difficult and awkward. Eating from a plate with knife, fork, and spoon will not be possible. A number of interesting phenomena would occur when ordinary methods of eating and drinking are employed in a space ship in a state of weightlessness. If a piece of meat should slip while being cut, it would fly off the plate and splatter against the wall, bounce back and then continue to bounce back and forth off the walls, ceiling, and floor. A fork full of peas raised to the mouth would continue in its upward flight to the ceiling and be reflected back, bombarding like buckshot. A cup of coffee raised to the mouth would result in the astronaut's receiving the contents in his face. To avoid these frustrating experiences, it is necessary to confine foods and liquids in containers from which they can be squeezed into the mouth. In lieu of the usual utensils, liquids and semi-solids can easily be served from collapsible "squeeze" tubes. Solids in bite size form can be removed by hand from a covered container and placed directly into the mouth. *Beatrice Finklestein, M. S. and Lt. Col. Albert A. Taylor. USAF. Food, Nutrition and the Space Traveler. Am. J. Clin. Nutrit. November-December 1960.*

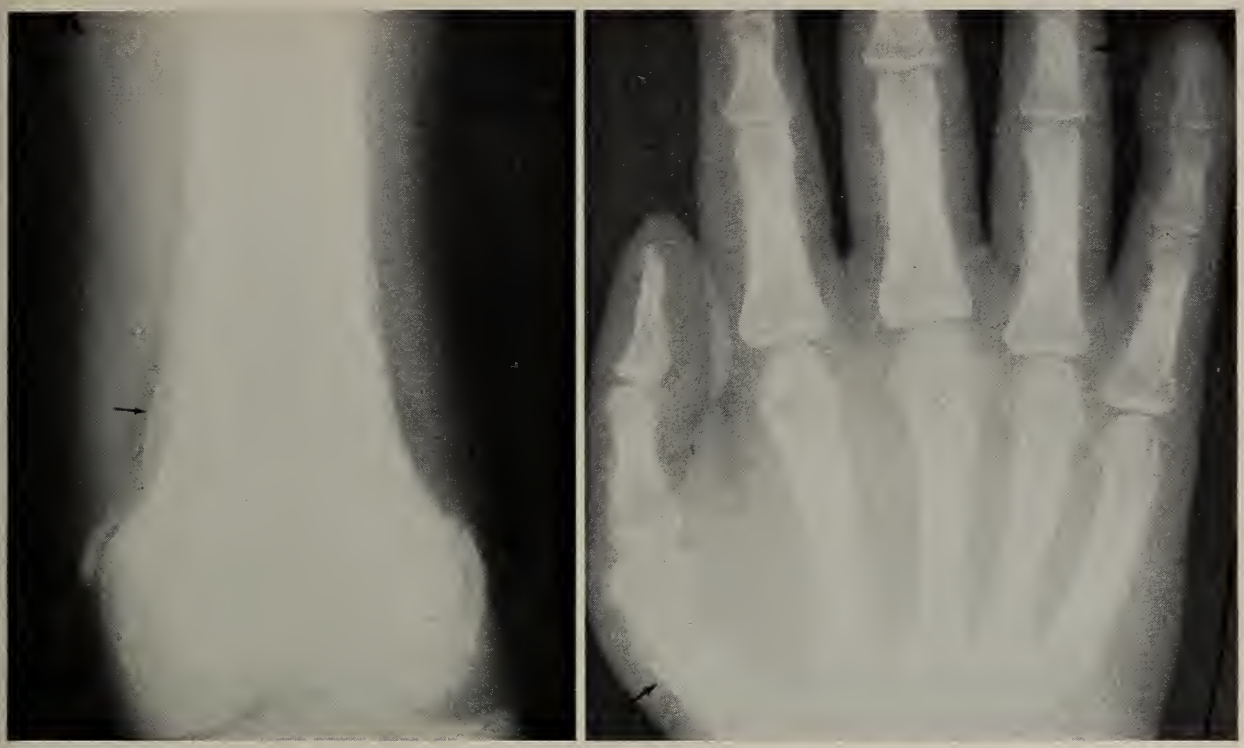


Figure 2. Involvement of tubular bones of the leg and hand showing thickening of the periosteum.

The View Box

—diagnosis and discussion (*continued from page* 156)

The considerable periosteal reaction involving all the visualized tubular bones of the upper and lower extremities is diagnostic of hypertrophic osteoarthropathy. This disease is also known as osteoarthropathia hypertrophiante pneumonique, and Bamberger-Marie.

The chest roentgenogram showed a middle lobe consolidation, which on bronchoscopy and biopsy proved to be secondary to an obstructing squamous cell carcinoma.

The syndrome of osteoarthropathy is characterized by thickening of the periosteum, lymphocytic and plasmo-cellular infiltration, osteoid formation with subsequent laminated calcification of the periosteal layers.

Any age group may be involved: however, it is rare in childhood and must be differentiated from nonspecific periostitis.

The clinical significance of the condition is that it may precede or coincide with the early stage of underlying disease:

1. Primary osteoarthropathy without underlying organic disease entity is rare (acropachydermia).



Figure 4. Middle lobe consolidation.

2. Secondary osteoarthropathies are seen in a variety of diseases:
   a. Chronic pulmonary suppurative processes and neoplasms (very uncommon in tuberculosis).
   b. Cholangitic cirrhosis and liver abscesses.
   c. Chronic diarrhea associated with ulcerative colitis, regional enteritis, and intestinal polyposis.
   d. Congenital heart disease (rare).
   e. Localized myxedema.

Differential diagnosis

Periostitis due to venous stasis (lower extremities, not symmetrical).

Syphilitic periostitis: most commonly involving tibias, rarely other osseous structures.

Nonspecific periostitis: not symmetrical.

Paget's disease: associated with bowing of the bone and coarsening trabeculation.

Cause of the syndrome is unknown, although a multitude of theories have been entertained such as toxic, endocrine, and neurogenic disturbances.

Prognosis

Prognosis is good for the secondary osteoarthropathies. After removal of the eliciting cause, or vagotomy, the bone pain may subside within 24 hours. More or less complete resolution of the subperiosteal bone, depending upon whether or not it has already become firmly incorporated into the cortex of the shaft, is often observed.

FURTHER READING

1. Skorneck, A. B., and Ginsburg, L. B.: Pulmonary Hypertrophic Osteoarthropathy (Periostitis): Its Absence in Pulmonary Tuberculosis. New England J. of Med. 258:1079 (May 29) 1958.

2. Camp, J. D., and Scanlan, R. L.: Chronic Idiopathic Hypertrophic Osteo-Arthropathy. J. of Radiology 50:581 (May) 1948.

April 19, 1960 Springfield

Third Annual

JOINT HOSPITAL CONFERENCE

Hospital Trustees, Chiefs of Staffs, Administrators

Sponsored by: ILLINOIS STATE MEDICAL SOCIETY
ILLINOIS HOSPITAL ASSOCIATION

TOPIC: **Hospital Utilization**

Panel Discussion *Workshop Sessions*

Case Study — 10th Councilor District, Pennsylvania

ALL PHYSICIANS WELCOME

8:30 A.M.—3:30 P.M. LELAND HOTEL

OFFICIAL BUSINESS

Statement on Policies and Programs On Health Care of the Aged

National events have focused increased attention on the health care of the aged. Long before this national interest was generated, the Illinois State Medical Society and its component county societies were aware of the specialized problems of health care for older people. At the state level and in many of the county societies special committees were appointed to look into these problems. At the state level we were instrumental in marshalling the resources of the hospital and dental and nursing home associations through formation of the Illinois Joint Council to Improve the Health Care of the Aged. Medicine and the allied professions have pledged themselves to a dedicated and continuing effort to meet all the health needs of the aged.

Much of this work has been overshadowed by the publicity surrounding efforts of certain national groups to incorporate health benefits into the social security system. To emphasize the work which the state and county medical societies have been doing and to set forth in one concise statement the policies and programs which medicine supports, the Council of the Illinois State Medical Society, in December, adopted a 12-point statement. The 12-points in brief are as follows:

1. Stimulation of Realistic Attitudes Toward Aging

The older individual should be maintained as a healthy participant in the family, civic, economic, and political life of the community, not isolated on the basis of arbitrary differences in age. Chronological age should not be the sole criteria for compulsory retirement. Such an attitude is vital to the physical and mental well-being of the aged. Every effort should be made to stimulate this proper attitude.

2. Responsibility of Financing Health Care of the Aged

The cost of personal health care is primarily the responsibility of the individual and his family. When these sources are not adequate, he should first look to his local community for help before resorting to governmental assistance. Federal participation should be limited to financial assistance to the states for locally administered and locally operated programs. The individual should be permitted and encouraged to remain self-supporting where possible. During the past two decades the economic problems of the aged have been intensified by erosion of the purchasing power of the dollar. All segments of the community, including government, should be encouraged to refrain from embracing activities which are inflationary in character and which, in turn, reduce fixed pension and annuity benefits of the older population.

3. Extension of Prepayment and Insurance

A majority of the people over 65 are not indigent. Within reasonable limits they can meet the costs of adequate health care from their own resources or by means of prepayment and insurance. Benefits and initial coverage have been expanded with the cooperation of the physicians of Illinois. Physicians will support further efforts to develop still better programs for older persons, both employed and retired, with appropriate attention given to the needs of patients requiring long-term and chronic care. Voluntary prepayment plans and health insurance can and

should provide the basis for meeting the health care costs of most people.

4. Contribution of Physicians to Low Income Groups

Traditionally physicians have provided care to their patients without regard for the ability to pay. Through hospitals, clinics, and a multitude of voluntary programs, physicians volunteer their services to the aged. The physicians of Illinois will continue, as they have in the past, to provide medical services to the aged, at fees they can afford or without charge, as the resources of these patients indicate. The society reaffirms its position that no patient, aged or otherwise, need go without adequate medical services by virtue of inability to pay.

5. Extension of Governmental Programs for Care of the Aged

Comprehensive health care is now available to indigent aged citizens of Illinois under old age assistance (OAA). The Mills-Kerr Bill as passed by the last Congress, when properly implemented in Illinois, will fulfill all additional governmental responsibility by providing medical care for the medically needy aged. The Illinois State Medical Society is currently cooperating in the development of such a program and urges its adoption in Illinois at the earliest opportunity.

6. Expansion of Skilled Personnel Training Programs

Increased emphasis is needed at all levels in the health field to provide adequate trained personnel to care for the growing number of aged. Training should be directed to all levels and with the total view of health as embracing social, psychological, and vocational aspects. Additional emphasis on recruitment of health workers is needed. The medical society and its Women's Auxiliary will continue existing efforts.

7. Improvement of Medical and Related Facilities and Services

More adequate facilities for the care of older people are needed, particularly in the fields of long-term and chronic care, rehabilitation, and neuropsychiatric care. Greater emphasis is needed for programs designed to maintain older patients in their homes where medical conditions permit, such as home care programs including homemaker services. The state society and its component county societies have supported the drive for more facilities and improved quality of care. These efforts will be continued and intensified where possible.

8. Promotion of Health Maintenance Programs

The society has long been on record as supporting the principles of good health maintenance, which includes such things as proper diet, exercise, and living habits in earlier years to insure healthier later years, regular physical check-ups, early detection and treatment of diseases or disability.

9. Wider Use of Restorative and Rehabilitative Services

Full use of rehabilitation and restorative services is essential to the care of the aged so that older persons who are ill or disabled may return to independent or partially independent living at the earliest possible time. The society's efforts to stimulate physicians and allied health workers in the use of these services will continue.

10. Leadership and Cooperation in Community Programs for Older Citizens

The society endorses community activities for older people such as may be found in churches, senior achievement groups, "Golden Aged Clubs," and day centers. Emphasis should be given to programs which integrate the older person with the community as a whole.

11. Extension of Research in Both Medical and Socioeconomic Aspects of Aging

Medicine will continue to encourage, support, and participate in research on both the medical and socioeconomic aspects of aging.

12. Increased County Medical Society Activity

The state society and many county medical societies currently have active committees on aging. All county medical societies are urged to form special committees to take local leadership in the development of specific programs to improve the health care of the aged.

E. A. Piszczek, M.D.
Chairman, The Council

Present Status of
The Impartial Medical Testimony Rule

A report released on June 14, 1960, by Henry P. Chandler,[1] indicated that on May 31, 1960, there were 61,497 cases pending in the Circuit and Superior Courts of Illinois, and that more than 50,000 of them were suits for personal injuries. Subsequently, on Aug. 5, 1960, the Institute of Judicial Administration[2] reported that, although the average court delay in personal injury cases in the United States in 1959 was 11.1 months, the delay in Cook County, Illinois, was 70 months. Time, therefore, would seem to be taking its toll against those seeking their rightful day in court.

Several solutions are presently under consideration to alleviate the delay and congestion of cases in the Illinois courts. Among them is a Rule to permit Impartial Medical Testimony to be used at the instance of the court or counsel for either party to the litigation. The rule is welcomed by medical societies who have historically been interested in such a program because of their professional desire to improve the quality and standards of medical testimony. Medical societies are interested in the medical truth, honestly given, and uncomplicated by any considerations of partisanship or reward.

Should the rule become as valuable a tool in the Illinois court as it has in the United States Federal Courts, its effect will be invaluable in the determination of facts; in reduction of glamorized concepts of disability, damages, and the extent of injury or disease to a sensible level; in speed-up of the pre-trial process, and in settlements arrived at earlier and more equitably.

On Sept. 28, 1960, the Illinois Supreme Court approved the principle of Impartial Medical Testimony and appointed a committee of four lawyers to prepare a rule for adoption by the court. The committee was composed of Mr. Owen Rall, chairman, Mr. Bert Jenner, Mr. Peter Fitzpatrick, and the general counsel of the Illinois State Medical Society, Mr. Walter L. Oblinger. Subsequently, on Nov. 11, 1960, the committee submitted the following Rule to the Supreme Court of Illinois:

(Proposed)
Rule 17—2
IMPARTIAL MEDICAL EXPERTS

When in the discretion of a trial court it appears that an impartial medical examination will materially aid in the just determination of a personal injury case, the court, a reasonable time in advance of the trial, may on its own motion or that of any party order a physical or mental examination of the party whose mental or physical condition is in issue. The examination shall be made without cost to the parties by a member or members of a panel of physicians chosen for their special qualifications by the Illinois State Medical Society. A copy of the report of examination shall be given to the court and to the attorneys for the parties. Should the court at any time during the trial find that compelling considerations make it advisable to have an examination and report at that time, the court may in its discretion so order. Either party may call the examining physician or physicians to testify, also without cost to the parties. The court shall determine the compensation of the physician or physicians.

At the time the Rule was submitted, the court also heard opposition to the plan from Mr. Peter Fitzpatrick, who represented the viewpoint of certain plaintiffs' attorneys in Chicago. Following Mr. Fitzpatrick's argument, Mr. Oblinger presented a short rebuttal and then entered a plea for the enlargement of the rule to include some provision for its administration.

As the matter now stands, the court has before it Proposed Rule 17-2 and is expected to act upon it during the March Term of court.

Claude C. Gustine
Associate Counsel
Illinois State Medical Society

1. *State Court Administrator, now retired, June* 14, 1960.
2. *A non-profit organization with headquarters at the New University Law Center.*

EDITORIALS

The philosophy of modern physicians

Modern physicians and with them the whole organization of medical services in the United States are being weighed and judged. Since the most important characteristic of any individual is his philosophy, it is reasonable to inquire into the philosophy of the modern physician, and it is more reasonable that the modern physician inquire into his own philosophy and that he judge himself. To do this he must first decide what should be the philosophy of the good physician. It is, of course, what has been the philosophy of the good physician always. Before and above all else, it is the philosophy of the good man, and of this no better standard has ever been set than the Golden Rule — "To do unto others as you would have that others should do unto you."

If he follows this rule with sympathy and understanding, he will realize that his profession is also a calling and that his function in society is what the function of the physician has always been, — "to heal the sick, to relieve pain, and to abolish fear."

He will first of all see to it that he is skilled in his profession so that the trust his patients have placed in him is well placed.

He will regard each patient as a fellow human being who has come to him for help.

He will forget, as far as possible, that they are sources of income.

He will not keep them coming back to him for unnecessary visits or for injections of medicine which could as well be prescribed by mouth or which the patient could inject for himself.

He will not advise unnecessary operations.

He will not split fees.

He will adjust his fees, not on the basis of the services rendered, but on that of the patient's ability to pay without financial hardship, so that each patient will be happy to pay them.

Knowing that his function is to heal the sick, he will treat the indigent for nothing, the poor for little, and others for what fits reasonably into their income.

This I believe is the philosophy of the good physician. He who lives by it will be happy and successful. Were all physicians to practice it, the profession as a whole would have nothing to fear, and the public would not be led into the dangerous experiment of socialized medicine.

Jerome R. Head, M.D.

Chromosomal aberrations

The study of genetics was given impetus in 1956 when it was found that the normal human somatic cell contains 46 chromosomes instead of 48. The breakthrough occurred when the squash technic was developed to identify chromosomes. The adaptation of cell culture to chromosomal analysis, introduced in 1958, allows investigators to cultivate minute tissue biopsies that yield proliferating cells for study of their chromosome patterns.

Mitosis is arrested in metaphase by colchicine. Hypotonic saline is added to make the cells swell and to help in dispersing the chromosomes when slight pressure is applied on the glass slide (squashing). The dispersed chromosomes are stained, and the karyotype is determined after analysis is made. The chromosomes split, with each half attached to the other at a characteristic point. The pairs have been identified and aberrations studied for their possible clinical significance.

Various congenital and other disorders have been traced to mismatched chromosomes. Mongolism appears to be associated with an extra autosomal chromosome, whereas in Marfan's syndrome there is enlargement of the satellite of an autosome. An extra chromosome has been noted in some acute leukemias, and characteristic chromosomal aberrations occur with Kleinfelter's

(primary microrchidism) and Turner's (gonadal dysgenesis) syndromes.

The "super female" has an extra X chromosome (XXX). Until recently, this three X-er was observed only in the fruit fly, but an example turned up recently in a study on human cells. The patient was not a Marilyn Monroe or a Gina Lollobridgida but quite the opposite. This individual had underdeveloped breasts and infantile pelvic organs, and could not reproduce.

Other genetic defects include certain blood dyscrasias and metabolic disorders. Resistance to disease and to degenerative disorders also may fall into this category. The same can be said of susceptibility to rheumatic fever and hypertension. More recently, cancer researchers working on lung cancer tissue found an average of 79 chromosomes.

The future of genetics becomes brighter with each new discovery. It is reasonable to assume that man will find a way to produce a perfect matching of the chromosomes in order to prevent mongolism, certain mental and congential disorders, and problems of intersex. Scientists have uncovered some of the secrets of the complex substances that compose the genes, including DNA (deoxyribonucleic acid). Current research is stressing this chemical and its role in the makeup of the gene.

Solving nurse and intern shortages

The nursing situation becomes more critical as thousands of new hospital beds are being added to accommodate the increasing population and the greater demands for medical services. Recruitment continues, and refresher courses in nursing are offered in Chicago to encourage the thousands of inactive nurses throughout the metropolitan area to return to active duty. A total of 358 nurses have completed the refresher courses in the past three years.

Meanwhile, the National League for Nursing raises its standards, and institutions that fall below the line are closed. The 4-year collegiate school of nursing appears to be their aim, to which we cannot object except that they may educate themselves out of business. The practical nurse appears to be the answer to the current problem. More facilities should be available for training these people in order to maintain a high standard of nursing care.

Many hospitals are plagued also by a shortage of interns. There are many ways in which this problem can be solved, but not in the immediate future. Teaching hospitals, for example, could rely on clerks and residents. The recent graduate interns in a nonteaching institution. The second plan is to build more medical schools so that the number of graduates would approximate the number of available internships. The latest suggestion was made by Dr. Charles L. Hudson of Cleveland at the recent 57th Congress on Medical Education and Licensure. He suggested that we develop a physician's aide with sufficient training to serve as an intermediary between the hospital technician and the physician. He would be, in effect, a permanent extern hired to be of service.

This would require a curriculum consisting of two or three years of prescribed medical courses. The training would resemble that given to graduate students and nurses. The program would be designed and supervised by the college and would lead to a bachelor of science in medicine or bachelor of medicine degree upon successful completion of the course. The demand for this type of assistance would be tremendous.

Presenting the problem of smoking

"To smoke or not to smoke" is the question which arises daily in many offices where people with gastrointestinal disturbances and particularly peptic (gastro-duodenal ulcers) are seen. How should this question be answered, and is the same answer applicable to all such patients?

A review of data on the effect of smoking on the physiology of the G.I. tract reported by many observers fails to present the clinician with a nonrefutable answer to the above questions, but it offers him a basis for an intelligent discussion of the presenting problem.

Before proceeding with the evaluation of our data, it must be stressed that the effects of smoking are not as clear-cut as those of nicotine, because some of the effects of smoking may be attributed to other substances present in tobacco, e.g., pyridines, volatile acids, and tars. While the smoke from one cigarette may furnish 6 to 8 mg. of nicotine, only part of this amount is usually absorbed, depending upon the moisture of the tobacco, the speed of the smoking, the depth of inhalation and the presence of a filter or cig-

arette holder. The amount of nicotine absorbed depends also upon whether pipe, cigar, or cigarette is smoked (Goodman and Gilman, 1955).

Accordingly, some observers, (Gray, 1930, Friedrich, 1934, Crohn, 1938, Steigmann et al, 1954) found increased gastric secretion and acidity. Others (Ehrenfeld and Sturtevant, 1941) found that after smoking there is an increased response on the part of the stomach to test meals (alcohol). Another group (Batterman and Ehrenfeld, 1948) found that smoking decreased the effectiveness of antacids. The gastric secretion and motility were found by some observers to be influenced by the mood of this patient during smoking. On the other hand, some observers failed to find increase of acidity after smoking; indeed, some noted even depression (Schnedorf and Ivy, 1939, Johnson, 1929). Others noted no significant difference between the patient who smoked and those who refrained (Cooper and Knight, 1956, Schlicphake and Simmet, 1944, Hodges and Gilmour, 1950). Still others noted no difference in the effect on gastric acidity when standard or denicotinized cigarettes were used (Gray, 1930, Ehrenfeld and Sturtevant, 1941, Ivy et al, 1950).

More recently, however, a definite increase in gastric acidity was found in both hospital controls and peptic ulcer patients following smoking (Steigmann et al). These workers also noted that in both groups of subjects the increase in the acidity was more frequent and at higher levels following the smoking of one ordinary cigarette than of a filtered one. Moreover, they noted that gastric motility seemed to be less affected by smoking. Thus, antral motility was increased in two, decreased in three, and unchanged in five after two ordinary cigarettes, but increased in one and unchanged in nine after two filtered cigarettes. The fundic motility, however, was similar after both types of cigarettes. They, therefore, postulated that the decreased motility with the resultant poorer gastric emptying may result in increased gastric acidity. Similar observations on gastric motility after smoking were also made by others (Schnedorf and Ivy, 1939, Batterman, 1955, Cooper, Harrover, Stein and Moore, 1958).

The aggravation of dyspeptic symptoms by smoking has been reported by several authors (Hurst and Stewart, 1929, Bockus, 1944, Schindler, 1947), mainly on clinical grounds.

Recently, however, a careful study (Doll, Avery-Jones, and Pygott, 1956) of a larger series of patients and controls seemed to indicate that there were fewer nonsmokers among ulcer patients; that the male ulcer patients began to smoke at an earlier age and that more ulcer patients smoked only cigarettes. It was also noted that in the patients who were advised to stop smoking, the ulcer healed more rapidly. The conclusion from the above observation was that smoking interferes with the healing of a peptic ulcer and helps to maintain its chronicity.

In another study it was found that the mortality from peptic ulcer was lower among nonsmokers, and increased with the amount of tobacco smoked (Hammond and Horn, 1958). On the other hand, it seems that the distribution of peptic ulcer mortality is not like the distribution of tobacco smoking, so that the latter may not be direct cause of ulcer but rather contributory to chronicity, by interfering with healing. A direct causation between ulcer and smoking, however, seemed to have been shown in dogs (Toon, Cross, and Wangensteen, 1951).

The effect of smoking on the intestinal tract is less well known. Some found no effect on the colon from smoking one cigarette; however, other workers have noted that smoking augments the motor activity of the colon (Schnedorf and Ivy, 1939). The observations of some patients that a cigarette after breakfast promotes defecation has hence a pharmacological basis. These findings would therefore suggest that patients, who a priori have a motor neurosis, e.g., irritable bowel, colitis, etc., would be better off not to smoke.

The few studies to date on the effect of smoking on the biliary tract and pancreas have failed to show any effect (Schnedorf and Ivy, 1939, Koehler et al, 1947). Similarly, there are no conclusive data on the effect of smoking on appetite and digestion, although some patients claim that they gain weight when they stop smoking (Kochler et al, 1947).

The brief review of some of the opinions concerning the physiologic effects of smoking (nicotine) on the gastrointestinal tract demonstrates the predominantly unfavorable results of smoking on this system. While there may be differences in the effect and in the individual, one cannot escape the conclusion that for patients with gastrointestinal disturbances it might be better

not to smoke. The majority of patients will follow their doctors' advice for reducing or stopping the smoking habit if the clinicians would clearly present to them the problem involved and the gains to be had from such an action.

Frederick Steigmann, M.D.

Time for action

Many forces are trying to change the physician profile in order to downgrade organized medicine and promote socialistic medicine.

Aime Forand, former Democratic representative from Rhode Island, let the cat out of the bag when he stated, "If we can only break through and get our foot inside the door, then we can expand the program after that."

The Forand type of legislation is not dead. We cannot afford to relax, because President Kennedy has committed himself before Congress in favor of this type of legislation. In addition, we members of the profession must cooperate fully with the new Federal-State program—the Kerr-Mills Bill—for medical care of needy and near-needy older persons. Illinois must participate as soon as possible.

Avoiding malpractice suits

A set of precepts to help physicians avoid involvement in malpractice litigation was suggested by Dr. Russell S. Fisher, Baltimore, Chief Medical Examiner of Maryland, to a recent scientific meeting here of the Utah State Medical Association. His advice includes the following:

1: You don't have to accept a patient. But once you invite him into your examination room, take a history, and do a physical; he is in your charge.

2: Do not terminate care too soon or fail to have another physician look after your patients if you are going to be away.

3: Keep your patients well informed of their condition and what hazards may be involved in certain treatments.

4: Always take x-rays in cases of bone or joint injuries.

5: Use the ophthalmoscope and other medical aids whenever indicated.

6 : Give tetanus antitoxin in cases involving penetrating wound, even though the patient may have been immunized previously with tetanus toxoid.

7: Be sure that there has been an accurate crossmatching before administering a blood transfusion.

8: Don't neglect to make frequent blood studies, such as clotting time determinations, whenever anticoagulants are being given.

9: If you are a surgeon, be sure you have the patient's or guardian's consent for the surgery you are to perform.

10: Tell your patients you will do the best you can for them, but don't promise too much.

11: Take care in the selection of assistants and the duties delegated to them.

Dr. Fisher urged physicians to avoid criticism of colleagues. *Russell S. Fisher, M.D. Precepts Set Up on How to Avoid Malpractice Suit. Medical Tribune. Oct.* 24, 1960.

Correspondence

Dear Dr. Ratner:

Thank you very much for the reprint of the magnificent panel discussion on polio vaccines, originally published in the Illinois Medical Journal. I look forward to receiving the bibliography and can only regret that the Journal did not include the bibliography along with the text.

The panel discussion you so ably moderated seems to me to bring together in one place the most impressive indictment of the Salk vaccine that I have seen. This has been the unanimous opinion of the people here to whom I have shown the reprint. We are all apprenhensive lest the information be lost to large segments of the public by reason of the limited circulation of the medical journal. The handling of the Salk vaccine seems to me to have important implications for the future handling of scientific problems in this country.

Sincerely,
Louis Lasagna, M.D.
Co-Editor,
Journal of Chronic Diseases

AT THE EDITOR'S DESK



More Shotgun Mixtures

There is an increasing tendency among drug firms to combine old remedies and call them new products. Plaquenil, for example, is effective against arthritic symptoms. So is aspirin. Winthrop Laboratories recently combined the two and calls it Planolar. We have a hunch that the consumer will pay more for that combo than he would if he bought the two drugs separately.

Plaquenil sulfate, 200 mg. tablet, sells for approximately 15 cents per tablet, whereas a penny will buy a 5 grain aspirin. Planolar costs 7 cents per tablet, but it contains only 60 mg. of plaquenil which is 1/3 that in the 200 mg. tablet.

Winthrop went a step farther in developing a new prescription tablet that they claim will control all cold symptoms. This is Win-Codin, an ethical mixture of codeine, Neo-Synephrine, aspirin, chlorpheniramine maleate, and ascorbic acid.

Our main objection to shotgun mixtures is that they are not aimed at the underlying disease nor the most distressful symptom. All too often the dosage of each drug in the mixture varies from a twelfth to half that required to relieve a specific symptom. Under these circumstances a single ingredient at full strength might bring faster relief. Your editor could be wrong, considering the popularity of these products. There are 600 ethical and over-the-counter cough remedies, most of which are of the shotgun mixture type. According to Medical Letter, "Whatever the mechanism of the cough disturbance, some pellets from the shotgun, it is hoped, will reach the target."

Process Speeds Radiography

The Polaroid Corporation has a new radiographic process that produces finished pictures in 10 seconds. The new process "MD/RR" is 10 to 15 times more sensitive than conventional radiographic technics and reduces x-ray exposure by approximately 80 per cent.

Cover for Massive Burns

Synthetic skin grafts have been maintained on animals for periods up to 104 days. Dr. William M. Chardack from the VA Hospital in Buffalo used a combination of Polyvinyl sponge and silicone rubber for this purpose. It is rigid when dry but becomes soft, pliable, and elastic when moist.

As the graft takes, the surgical sponge is permeated by the tissue and becomes adherent within a few days. The coating of silicone makes it waterproof.

Dr. Chardack will use this synthetic skin to cover burned areas too large to cover with the healthy skin of the victim. It should prevent fluid loss and infection.

Computer's New Score

The "play on words" department gives its award this month to Remington Rand. They have a news release entitled, "UNIVAC to Reduce Infant Death and Disease." These computers are wonderful. We hope the data collected will do just that.

Neoplasms in A-bomb Survivors

The following summary was reported by the research committee on tumor statistics, Hiroshima City Medical Association.

"The 1957-58 incidence of neoplasms among the survivors of the Hiroshima A-bomb varies directly with radiation dose, insofar as it may be inferred from distance from the hypocenter at exposure. The incidence of all malignant neoplasms among the survivors who were within 1000 meters is more than 4 times that of the nonexposed population. The incidence of benign neoplasms among the survivors exposed within 1500 meters is also significantly higher than that among the nonexposed. For survivors under 1500 meters there are significant differences between

the number of observed cancers of the lung, stomach, uterus, and ovary and the expected cases calculated from the age-specific rates of the nonexposed portion of the Hiroshima population. The increased incidence among survivors within 1500 meters is not related to sex or age."

Payola Seekers

We are familiar with the speaker at medical conventions who pads his paper with data from outdated texts and meaningless statistic. These are payola seekers, according to Dr. Hugh Smith of Memphis. They gain the reward of attention by wasting the time of other people.

Dr. Smith made this point at the Miami meeting of the American Academy of Orthopedic Surgeons. He mentioned other forms of payola including the malignant type which is carried out in the office by the man who fuses every aching back and charges what the market will bear.

He wanted to make it clear, that there are legitimate rewards for honest effort, but they do not come from the shoddy, the lazy, the dishonest, nor the selfish.

Moving X-ray Pictures

Zenith has a new pulsed x-ray system for taking motion pictures of high speed phenomena. The exposure times are one millionth of a second or less and only 1/4000th of a second apart. An idea of its "stop motion" capability was demonstrated with a speeding bullet travelling at 4,000 feet per second. It was "stopped" in flight by flash x-rays; a second exposure of 1/4000th of a second showed the same bullet about one inch further along in flight.

The machine should offer the radiologist new information which x-ray films still can't provide. This applies to the lungs, heart, blood vessels, and other moving systems. It also has many industrial uses. The price is in the forty to fifty thousand dollar range. There was no hint in the report of an "only one to a customer" sort of a deal.

The Dentist's Work-Week

According to the ADA, dentists average 43.1 hours a week at the office. Of this time, 34.2 hours are spent at the chair, 3.8 hours devoted to laboratory work, 2.5 hours are consumed by other work, and 2.6 hours are free time.

The survey showed also that the number of days absent from work because of illness varied from 1.1 annually for dentists under 30 to 5.6 days for dentists in their sixties. More than two thirds of the dentists over 60 and half the dentists in their thirties had not lost time because of illness. We assume from this that only the healthy dentists survive or perhaps that dentists get stronger with age.

Early defense

A comparison was made on baby pigs receiving their mother's milk and those on an experimental diet. The latter included cow's milk, simulated cow's milk, amino acids, short-chained peptides, vitamins, and minerals. The piglets on the real McCoy developed mature serum profiles within 14 days. Those on cow's milk required four to seven days longer. Those on the artificial cow's milk took even longer; many developed diarrhea and died.

The research project hints that mother's milk helps build the young animal's antibody defense against disease.

Smallpox Control Measure

Hereafter all travellers arriving from Cuba will be required to show evidence of valid vaccination for smallpox. Although smallpox is not known to exist in Cuba at present, the Surgeon General said the action is necessary because exemption from immunization requirements can be maintained only when there is close liaison between the Public Health Service and the official health agency of the exempt area. Since direct accessibility to health information is no longer available, quarantine regulations must be applied to Cuba to minimize the danger of the introduction of disease into the United States.

Absorbable Hemostatic Material

Surgicel is Johnson & Johnson's new surgical absorbable hemostatic agent. The dressing is a synthetic cellulosic fiber made from an oxidized regenerated cellulose. It is used to control troublesome bleeding or oozing from raw surfaces where no blood vessels can be clamped or con-

trolled with electrocautery. The dressing is said to be safe and effective as absorbable hemostatic material. It was used successfully in the control of bleeding from fabric grafts in vascular surgery and from retropleural and retroperitoneal surfaces.

Automatic Cell Counter

A new, economically priced optical-electronic cell counter has been developed by Sanborn Company for use in large and small laboratories. It is reported to count red and white cells accurately, more rapidly, and with less operator fatigue. Total cells sampled is about 50 times that of a manual count. Readout is direct without need for conversion or correction factors.

The Statistical Corner

• There are 236,089 physicians in the United States, a ratio of 133.4 per 100,000. The trend is definitely toward specialization. There are three and one-half times more full time specialists and five times more physicians in federal service than there were in 1931, but the number of M.D.'s in general practice has declined.

• The accident toll is approximately the same as it was last year (92,000). Motor vehicles were responsible for the loss of approximately 38,000 lives. Accidents in and about the home took 26,500 lives—an increase of 500.

Less Money for Less You

A do-it-yourself, measured calorie drink, 95 per cent identical to those bought over grocery and drug counters, can save dieters $25 a month. It is being publicized by Mr. Vic Friedman of V. E. Friedman Associates of New York, and we take no credit for the cost of each item nor his chemical experience.

The recipe: Dissolve one multi-vitamin pill (2 to 3¢) in one quart of chocolate milk (about 25¢). Add 1½ ounces of powdered milk (4¢). The mixture is reported to contain twice as much of vitamins A, B, and B_{12}; twice as much iron, riboflavin, thiamine. The powdered milk (an ounce and a half of calcium caseinate) fortifies calories, protein, and calcium. To check this, he says, get the U.S. Department of Agriculture Handbook 8—and read the vitamin bottle label.

We hope Mr. Friedman has tried to make this formula in his kitchen before recommending it.

FDA Drug Labeling Regulations

Labeling used to promote sale of prescription drugs to physicians, originally proposed by the FDA, have been somewhat modified.

Major changes required by the new regulations are:

1. Labels of drugs for injection must declare the quantity or proportion of all inactive ingredients. Previous regulations have not required quantitative declaration.
2. Labels of prescription drugs will have to bear identifying lot or control numbers from which it is possible to determine their manufacturing history.
3. Any labeling of prescription drugs or devices including promotional literature mailed or given to physicians by company representatives which furnish information about uses or dosage must contain complete information for professional use, including information about any relevant hazards and conditions in which the drug should not be used.

However, this will not apply to so-called "reminder piece" literature which merely mentions the name of the drug but does not give indications or dosage recommendations.

4. If the drug is new, information about uses, dosages, hazards, and contraindications must be substantially the same as that contained in the application to market the drug.

Advertising or oral detailing for a new drug may offer it only for use under the conditions specified in the labeling contained in the application to market the drug.

Labeling or advertising which goes beyond the claims approved in the labeling must be resubmitted for approval in advance of use.

5. Labeling bearing information about uses and dosage must show the date of issuance or latest revision.

Required changes on labels and cartons and the dating of labeling for professional use became effective on March 9, 1961. All other changes including the requirement for full information for use and disclosure of the hazards of the drug in promotional labeling mailed or detailed to physicians, became effective on Jan. 8, 1961.

ANNOUNCEMENTS



Radiation installation defects

The Illinois Department of Public Health reports it found defects in 51 of 160 industrial radiation installations surveyed to date. Eighty-one per cent of the defects have been corrected, and the remaining 19 per cent are being corrected.

The radiation inspection program was begun by the state department of public health last year, making Illinois one of the first states to enact and implement a radiation protection act. All 270 industries in the state with radiation installations are registered by the department; 110 are yet to be inspected. Trained radiological health experts determine if radiation devices are being used in accordance with provisions of the act.

Defects in equipment most frequently involved inadequate filters, poor shielding, over-exposure, no warning light, and contamination. The largest number of defects was found in industrial medical clinic x-ray machines, with industrial x-rays next in number.

Aid to Cuban physicians in U.S.

Cuban physicians and surgeons relocating in the United States since diplomatic difficulties with the Castro regime are being aided financially and with job offers by the International College of Surgeons, according to Dr. Walter F. James, executive director of the college.

The college and individual members are contributing to a special fund through the Leonard Wood Memorial Fund for Relief of Cubans, distributed by the Department of Health, Education and Welfare, with the final approval of its new head, Gov. Ribicoff.

HEW has disclosed that there are 66,000 displaced Cubans in this country, many of whom are physicians and surgeons now doing odd jobs or manual labor. Even though these doctors cannot practice in this country until accredited, the college has enlisted the help of its surgeon members to find jobs for them requiring technical skills in hospitals and clinics throughout the United States.

The University of Miami School of Medicine at Coral Gables is now offering postgraduate training for these refugee physicians.

Symposium on Delinquency

The Chicago Pediatric Society's monthly meeting will be held in the Auditorium of the Nurses' Home of Children's Memorial Hospital on Tuesday, March 21 at 8 p.m. Joseph D. Lohman, treasurer, State of Illinois, will speak on "Sociological Aspects of Juvenile Delinquency," and Dr. James B. Gillespie, Carle Hospital Clinic, on "Medical Aspects of Juvenile Delinquency." It is an open meeting.

Academy of Pediatrics session

The spring session of the American Academy of Pediatrics will be held at the Sheraton-Park Hotel in Washington, D.C., April 10-12.

In addition to individual papers to be presented, panel discussion will take up "The Role of Viruses in Respiratory Tract Disease;" "Placental Transfer of Noxious Agents;" "Common Gastrointestinal Problems;" and "Clinical Implications of Enzyme Maturation." Several television presentations also have been scheduled.

The banquet will be on Tuesday.

Course in neuromuscular diseases of children

The Cook County Graduate School of Medicine announces a two-week intensive course in Neuromuscular Diseases of Children with Spe-

cial Emphasis on Cerebral Palsy, to be given by Dr. Meyer A. Perlstein June 12 to June 23. This is an intensive didactic and clinical course designed for pediatricians, orthopedists, neurologists, psychiatrists, and physiatrists.

Emphasis will be placed on the practical clinical aspects of treatment and rehabilitation procedures. The course will include trips to demonstration clinics and treatment centers. The fee for the course is $285.

Since registration will be limited, applications should be made as far in advance as possible. For further information, write John W. Neal, Registrar, Cook County Graduate School of Medicine, 707 S. Wood St., Chicago.

Medical Assistants proceedings

A compilation of speeches on medical office management and patient relations given at the second annual convention of the American Association of Medical Assistants in Dallas, Texas, last October is now available on request. To obtain copies of the proceedings write Department PR-1, Lakeside Laboratories, Inc., 1707 E. North Ave., Milwaukee 1.

Chicago Urological Society meeting

Dr. J. Kenneth Sokol will deliver the president's address before the society meeting at the Morrison Hotel April 12 at 7:30 p.m. Three candidates' theses also will be presented.

At the March program of the society a symposium, "Hydronephrosis Secondary to Ureteropelvic Obstruction," was moderated by Dr. Cornelius W. Vermeulin, University of Chicago. Participants were Dr. Ormond S. Culp, Mayo Clinic; Dr. Frank C. Hamm, State University of New York, Brooklyn; Dr. Frank Hinman, Jr., University of California Medical Center, San Francisco; and Dr. Robert Lich, Jr., University of Louisville.

Gastroenterologist's regional meetings

The Southern Regional Meeting of the American College of Gastroenterology will begin in Houston, Texas, on Sunday, March 19 in the Jesse H. Jones Library Building of the Texas Medical Center. The chairmen are Dr. Ralph E. Eichhorn, Houston, and Dr. H. B. Eisenstadt, Port Arthur, Texas.

The Western Regional Meeting of the College was held in San Francisco on Sunday, March 5 in the Fairmont Hotel. Dr. Samuel W. Yabroff, Oakland, will be chairman.

To obtain copies of the programs write the Secretary, American College of Gastroenterology, 33 W. 60th St., New York 23.

Ob-Gyn. meeting

The annual meeting of the Illinois Obstetrical and Gynecological Society will be held Monday May 15, the day preceding the sessions of the Illinois State Medical Society, in the Sherman Hotel.

Mark your calendar and look for the program in the next issue of the Journal.

International College of Surgeons lectures

The 1960-61 season's series of lectures for the International College of Surgeons continues on April 4 with Dr. Alexander Rytel's presentation on "Polish Contributions to Medical Science" at the Hall of Fame. He is president of the Polish Medical Alliance in Chicago.

On April 18 Dr. Philip Thorek, surgeon-in-chief and administrator, American Hospital, will speak on "Food for Thought," and on May 23 Dr. William B. Serbin, senior attending obstetrician-gynecologist, Chicago Wesley Memorial Hospital, will end the season with a lecture on "Physician Signers of the Declaration of Independence."

All programs begin at 8:00 p.m.

International Congresses

The International Congress of Allergology will be held at the Hotel Commodore, New York City, October 15 to 20. At the main meetings, there will be simultaneous translations of all papers in English, French, German, and Spanish. Prominent physicians and scientists from all parts of the world have been invited to take part in conferences, symposia, and panel discussions. Among the subjects to be presented are genetics in allergy, acquired tolerance, transplantation immunity, drug hypersensitivity, contact allergy,

general mechanisms in allergy, mechanisms of antibody fixation, delayed hypersensitivity, auto immune processes, steroid therapy, and new methods in allergy.

Entertainment is being arranged with several receptions, a banquet, and a program for the ladies.

The registration fee for members will be $45, for wives, $20. It includes the printed proceedings and admission to the receptions. Persons interested in obtaining additional information should write to Dr. William B. Sherman, 60 E. 58th St., New York 22.

The Inter-American Congress of Radiology will be held in Sao Paulo, Brazil, September 3 through 9. Scientific sessions will be in three categories: radiodiagnosis, nuclear medicine, and radiotherapy. A series of seminars, symposia, and conferences within the three congress categories are planned, in addition to individual papers and essays.

Two basic trips of 18 and 26 days each through Brazil and Latin America are available for college members and their families from the Lee Kirkland Travel Organization, Kansas City, Mo. Special travel schedules may also be arranged through the agency.

For further information write the Lee Kirkland Travel Organization, 1231 Baltimore Ave., Kansas City 5, Mo.

Medical clinics officers

The American Association of Medical Clinics at its annual meeting in New Orleans elected the following officers: Dr. Harold D. Caylor of the Caylor-Nichel Clinic, Bluffton, Indiana, president; Dr. Bernard A. Watson, Clifton Springs Sanitarium Clinic, Clifton Springs, N.Y., president-elect; Dr. John R. Hand, Portland (Ore.) Clinic, second vice president; and Dr. Joseph B. Davis, Davis Clinic, Marion, Ind., re-elected secretary-treasurer.

Surgical clinic

Prof. Ian Aird, University of London, and director of the surgical unit, Post Graduate Medical School, London, England, and Robert M. Zollinger, M.D., chairman, department of surgery, Ohio State University, will conduct a three-day clinic at the Cleary Auditorium, Windsor, Ontario, Canada, April 26-28. The registration fee is $25. Accommodations are available in Windsor and Detroit.

This meeting is sponsored by the Essex County Medical Society and the Ontario Medical Association. For information, write: Registrar, 301 Canada Bldg., Windsor, Ontario.

PG program in Israel

The University of California School of Medicine, in cooperation with the Hebrew University-Hadassah Medical School in Jerusalem and the Beilinson and Tel Hashomer Hospitals in Tel-Aviv, is offering a clinical postgraduate program in Israel April 20 through May 7.

The program offers an opportunity for physicians from the United States to visit in the homes of Israeli physicians and to participate in numerous social events which have been planned, in addition to attending the medical program.

For further information write Mrs. Bettie Minifie, Assistant Head, Continuing Education in Medicine and Health Sciences, University of California, University Extension, Los Angeles 24.

Teaching film on allergy

"Frontiers of Allergy" is a new 16 mm 25-minute color sound film supported by Schering Corporation, pharmaceutical manufacturer, and made with the technical guidance of Dr. Leo H. Criep, clinical associate professor of medicine, School of Medicine, University of Pittsburgh.

It affords a visual presentation of the over-all subject of allergy from its basic mechanisms to methods of treatment. All of the live sequences were photographed in Pittsburgh at the VA Hospital, Montefiore Hospital, and the University of Pittsburgh.

The film includes both a basic science and clinical approach to the subject of allergy. It may be obtained on loan without charge by writing to the Audio-Visual Department, Schering Corporation, 1011 Morris Ave., Union, N.J.

Basic course in ophthalmology

The Chicago Ophthalmological Society has organized a full-time residency preparatory Basic Course in Ophthalmology to be conducted

once each year. The first starting date will be July 10. The course has been designed primarily for physicians planning to specialize in ophthalmology. It has been planned to run for five months.

Cooperating in the planning and presentation are Chicago's five undergraduate medical schools, several of the teaching hospitals, and Cook County Graduate School of Medicine. Registration will be limited to thirty graduate students. For further information write to Registrar, Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 12.

Crippled children clinics

April 4 — Carrollton, First Baptist Church
April 5 — Alton (Rheumatic Fever), Alton Memorial Hospital
April 5 — Hinsdale, Hinsdale Sanitarium
April 5 — Rock Island (Cerebral Palsy), Foss Home, 3808-8th Ave.
April 6 — Cairo, Public Health Building
April 6 — Flora, Clay County Hospital
April 7 — Chicago Heights (Cardiac), St. James Hospital
April 11 — East St. Louis, St. Mary's Hospital
April 11 — Peoria, Children's Hospital
April 12 — Champaign-Urbana, McKinley Hospital
April 12 — Springfield, St. John's Hospital
April 14 — Evanston, St. Francis Hospital
April 18 — Belleville, St. Elizabeth's Hospital
April 18 — Danville, Lake View Hospital
April 18 — Quincy, Blessing Hospital
April 19 — Chicago Heights (General), St. James Hospital
April 20 — Elmhurst (Cardiac), Memorial Hospital of DuPage County
April 20 — Rockford, Rockford Memorial Hospital
April 25 — Effingham (Rheumatic Fever), St. Anthony Memorial Hospital
April 25 — Peoria, Children's Hospital
April 26 — Elgin, Sherman Hospital
April 27 — Bloomington (a.m., General; p.m., Cerebral Palsy), St. Joseph's Hospital
April 27 — Mt. Vernon, Masonic Temple

PG course in urology

The Frank E. Bunts Educational Institute affiliated with the Cleveland Clinic Foundation announces a postgraduate course "Current Urologic Problems" March 23 and 24 to be given in Cleveland.

Guest speakers will be Dr. Vincent J. O'Conor, Northwestern University School of Medicine, and Dr. Reed M. Nesbit, University of Michigan School of Medicine.

Registration will be limited to 125. The fee is $30. For applications write the Education Secretary, The Frank E. Bunts Educational Institute, 2020 E. 93rd St., Cleveland 6.

Watch for Your April Journal Which Will Publish

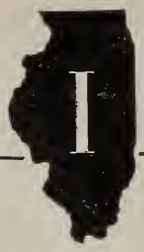
The Handbook

For The 1961 Annual Meeting ISMS

Delegates Will Not Receive Handbooks

***Prior* to Registration**

NEWS of the STATE



County

Cook

Presbyterian-St. Luke's New Health Center. A new $2 million Health Center to be constructed at Presbyterian-St. Luke's Hospital on West Congress Parkway will provide diagnostic and therapeutic services, together with a preventive medicine program.

In 1960 more than 70,000 outpatients were served by the hospital. The Health Center fulfills an important function in the teaching program of the hospital as well as offering an important service to the community. Presbyterian-St. Luke's is the only voluntary general hospital in the Medical Center District.

Construction of the new outpatient clinic, made possible through contributions from Field Enterprises Charitable Corporation, The Chicago Community Trust, The Silver Spring Foundation, and two large anonymous donations, is scheduled to start this summer and will be completed in one year.

Dr. Block to University of Chicago. Dr. George E. Block, who was a Fellow of the American Cancer Society at the University of Chicago Medical Center in 1955-1956, has returned to the university as an assistant professor in the department of surgery.

He has been an instructor in surgery at the University of Michigan, where he had received his M.D. degree in 1951, attending surgeon at the University Hospital and Veteran's Administration Hospital, and became assistant professor of surgery in 1960.

Course for Nurses Returning to Active Duty. The Chicago Council on Community Nursing has been offering refresher courses in nursing to spur the return of inactive nurses throughout the metropolitan area to active duty. The courses are free of charge and are four to six weeks in length. They include two hours of classroom instruction and four hours of supervised practice five days a week.

Five Chicago area hospitals have cooperated in giving the course. The last of the series begins April 17 at Lake Forest Hospital. It is open to all currently registered professional nurses, although the number accepted will be limited. Application forms may be obtained from the council, 8 S. Michigan Ave., Chicago, telephone CEntral 6-0464.

"X-ray Detective" Exhibit. The Museum of Surgical Science of the International College of Surgeons Hall of Frame has a new exhibit "X-ray Detective." Thirty-one radiographs are used to exemplify the x-ray tube's detection of forgeries in art works, stamp collections, porcelain, and other rare objects.

The collection is a gift to the Museum and represents many years of research by Dr. Herbert C. Pollack, chairman of the radiology section of the college, and Charles F. Bridgeman, director of laboratories of Eastman Kodak, Rochester, N. Y.

The exhibit opened to the public admission-free February 1 and will run indefinitely.

Elected. Dr. Harry B. W. Benaron, medical director at Chicago Maternity Center and associate professor of obstetrics and gynecology at Northwestern University, has been elected to the board of directors of the Exchange National Bank of Chicago.

Physician-Poet. Dr. Erwin P. Zeisler of Michael Reese Hospital has recently written a book of lyrical and descriptive poems entitled "Poems on Pertinent Topics" under the pen

name of Walter Erwin. A number of his poems have medical themes. Pageant-Press, New York, is the publisher.

Elections. Dr. Paul H. Holinger, University of Illinois College of Medicine, has been elected chairman of the board of the Institute of Medicine of Chicago. Dr. Louis N. Katz, director of the cardiovascular department at Michael Reese Hospital, became president, and Dr. Howard L. Alt, Northwestern University Medical School, was named vice president. Dr. Ernest G. McEwen, also of Northwestern, was reelected secretary, and Dr. E. Lee Strohl, board president of the Municipal Tuberculosis Sanitarium, was renamed treasurer.

The Chicago Dermatological Society at its annual meeting elected its new officers. They are Dr. Frederick J. Szymanski, president; Dr. Hans M. Buley, vice president; and Dr. Frederick D. Malkinson, secretary-treasurer.

The Chicago Diabetes Association has elected the following physicians as directors for terms expiring February, 1964: Dr. Donald I. Bell, Dr. Arthur R. Colwell, Sr., Dr. Ford K. Hick, Dr. William S. Hoffman; Dr. Henry T. Ricketts, and Dr. Charles S. Vil.

Officers elected for the year include Dr. M. David Allweiss, president; Dr. Ralph E. Dolkart, secretary; and Mr. George K. Dahlin, treasurer.

Honored. Northwestern University Medical School held a reception honoring Miss Edith Foster Sweet, director of the Medical School clinics, on her retirement after 35 years of service.

The reception was given by Dean Richard H. Young and the faculty and by the members of the Women's Service Club February 1.

Miss Sweet was a staff member on the medical school clinics from 1926 to 1950, became assistant director of the clinics, and in 1954 was named director.

Dr. Kirsner given Phi Lamda Kappa award. Dr. Joseph B. Kirsner, professor of medicine at the University of Chicago, was the winner of the Grand Scientific Award of Phi Lamba Kappa fraternity.

Drs. Stuart Levin and Jerome Goldflies of Chicago were made regional vice presidents of the fraternity.

Appointed: Dr. M. M. Hipskind, Chicago, was recently appointed clinical professor in the department of otorhinolaryngology and chairman of the Executive Committee of the department at Stritch School of Medicine of Loyola University.

Lecturer. Dr. Louis B. Newman, chief of physical medicine and rehabilitation at the VA Research Hospital, and professor at Northwestern University Medical School, addressed the Oklahoma State Heart Association and the Oklahoma City Internists' Association February 8 on "Physical Medicine and Rehabilitation in Total Patient Care."

ACS meeting. The Metropolitan Chicago Chapter of the American College of Surgeons held a panel symposium on "Pediatric Surgery" March 16 at the John B. Murphy Memorial Auditorium. Panel members from the staff of the Children's Memorial Hospital were Drs. Ovar Swenson, Joseph Boggs, Irving Schulman, and Harvey White.

Annual Pusey Lecture. Dr. William Montagna, professor of biology, Brown University, gave the Annual William Allen Pusey Lecture March 15 at the Illini Union. His subject was "The Sweat Glands of Man."

Du Page

Dr. Otto L. Bettag, former state director of public welfare, was named medical director of the Du Page County Tuberculosis sanitarium in Glen Ellyn. He has resigned as welfare department control officer, a post he took three days before his eight-year tenure as state welfare director ended, in order to assume his new position.

Macon

Dr. Lee O. Frech, who retired and moved from Decatur to San Diego, Calif., in 1959, has been named to the 50-Year Club of the Illinois State Medical Society. The certificate was presented to Dr. Frech at a recent meeting of the

San Diego County Medical Society by the president of the association.

Dr. Frech had practiced in Decatur since 1921 and at the time of his retirement was the second oldest pediatrician in Illinois in length of practice. He is a past president of the Central Illinois Pediatric Society.

Madison

Dr. and Mrs. R. C. Berry held an open house on February 12 at their home in Lebanon celebrating their Golden Wedding Anniversary.

Vermilion

Donald Martin, director of public relations of the Illinois State Medical Society, was the speaker at the joint January meeting of the Vermilion County Bar Association. His subject was "Mutual Problems of Doctors and Lawyers." Mr. Martin was formerly director of public relations for the Illinois Bar Association.

Winnebago

Dr. Roland I. Pritikin, Rockford, president of the Henry Holland Hospitals Alumni Association and Fund, addressed the Kobe (Japan) Society of Ophthalmology, the Hong Kong Ophthalmological Society, the Philippine Ophthalmological Society, the Department of Ophthalmology, University of the Philippines, and other ophthalmological groups in the Far East during January.

General

Dr. Coggeshall at WHO meeting in India

Dr. Lowell T. Coggeshall, vice president in charge of medical and biological programs of the University of Chicago, was a member of the United States delegation attending the World Health Organization meeting held in February in New Delhi, India. Dr. Coggeshall is an international authority on malaria and other tropical diseases. He was also recently elected to the board of directors of the Josiah Macy, Jr. Foundation, New York City.

The World Health Organization has 103 member nations and during 1960 assisted in more than 600 health projects in 126 countries and territories, with increased attention in areas which earlier had relatively little health protection.

Nurses' fund drive

The American Nurses' Foundation, research arm of the American Nurses' Association, is conducting a nationwide drive to raise $1 million for nursing research. Members of health professions, foundations, industry, and the general public are being asked to contribute.

The Illinois drive is sponsored by the Illinois Nurses' Association headed by Mrs. Ann Zercher, director of nurses, Louis A. Weiss Memorial Hospital, and Louis Zahn, president, Zahn Drug Company. Their goal is $100,000 of the total. The drive began in January and will run through Illinois Nurses' Week March 19-25.

Funds will be used for research in nursing procedures, effects on nursing of changes outside the profession, demands on nursing care of administrative units such as hospitals, clinics and health agencies, and nursing needs of patients in particular disease categories. Special emphasis will be placed on the nursing needs of the chronically ill.

Illinois fluoridation program

Eight more communities began using fluoridated water supplies to reduce tooth decay during 1960, bringing the state total to 123.

Illinois residents now drinking fluoridated water by choice number 5,204,694, and 611,540 persons are drinking water that is naturally fluoridated.

For the benefit of youngsters living in rural areas or communities where public water supplies are not fluoridated, the Illinois Department of Public Health has demonstration programs in the application of sodium fluoride directly to the teeth. Through these demonstrations and the resulting locally sponsored permanent programs, almost 14,000 children received the treatments last year.

The department is also establishing demonstration dental clinics in cooperation with several selected county health departments. The clinics are designed to provide dental care for children from low-income families. Special studies are

being made of tooth decay and gum diseases in children.

Disease in Illinois, 1960

Provisional 1960 figures for some reportable diseases in Illinois have been released by the State Department of Public Health.

Disease	1960	1959	Increase or Decrease
Gonorrhea	22,808	18,596	+4,212
Syphilis	8,577	8,510	+ 67
Diphtheria	9	10	− 1
Smallpox	0	0	0
Meningitis	697	713	− 16
Typhoid fever	19	18	− 1
Brucellosis	71	71	
Encephalitis	154	133	+ 21
Hepatitis	1,655	855	+ 800

Camp for diabetic children

This summer camp, under the auspices of the Chicago Diabetes Association, will be conducted from July 16 through August 6 at Holiday Home, Lake Geneva, Wis. Boys and girls from 8 through 14 years of age are eligible.

As in previous years, the camp will be staffed by resident physicians, a nurse, two dietitians, and a laboratory technician, in addition to the regular counseling and domestic staff.

Rates are arranged in accordance with individual circumstances.

Applications may be obtained from, and inquiries directed to the Chicago Diabetes Association, 620 N. Michigan Ave., Chicago 11. Telephone Superior 7-8842.

Deaths

George J. Baumgartner*, Forest Park, a graduate of the University of Illinois College of Medicine in 1924, died January 25, aged 63. He had been health commissioner of Forest Park from 1947 to 1959 and a staff member at Oak Park Hospital for 39 years.

Andrew E. Black, Chicago, a graduate of Northwestern University Medical School in 1906, died October 7, aged 80.

Robert L. Borchert*, Chicago, a graduate of the University of Illinois College of Medicine in 1910, died January 29, aged 72. He was on the staff of Swedish Covenant Hospital.

Ward P. Burdick*, retired, Rockford, a graduate of Bennett Medical College in 1912, died January 19, aged 78. He was on the staff of St. Anthony's Hospital for 33 years before retiring in 1949.

William J. Devlin*, Chicago, a graduate of the Stritch School of Medicine of Loyola University in 1947, died January 8, aged 55. He was ordained a priest in 1936, and in 1947 became the first Jesuit ever to receive an M.D. after becoming a member of the order. He was a diplomate of the National Board of Medical Examiners and a clinical assistant in the psychiatry and neurology department at Loyola's Stritch School of Medicine. He was also active in Loyola's Center of Psychological Guidance and served for two years in the neurological department and psychopathic ward of Cook County Hospital. Father Devlin was a staff member of the Illinois Neuropsychiatric Institute from 1949 to 1951, a fellow of the Institute of Juvenile research from 1951 to 1952, and a senior staff member of the institute from 1952 to 1955. In 1951 he went to England to help form the world's first association of Catholic psychologists. He was a member of the American Psychiatric, Psychological, and Ortho-psychiatric associations; the American Academy of Neurology; the American Academy of Psychotherapy; and Sigma Xi fraternity.

Howard T. Knight*, Elgin, a graduate of the University of Illinois College of Medicine in 1913, died February 3, aged 71. He had practiced medicine in Elgin since 1916.

Robert D. McCormick*, retired, Pompano Beach, Fla., a graduate of the Chicago Medical School in 1923, died February 1, aged 69. He was medical advisor to the Kraft Foods division of the National Dairy Products Corporation from 1929 to 1948. From 1952 to 1957 he was regional medical officer for the U.S. Civil Service Commission in Chicago. He had been a faculty member of the University of Chicago Medical College and had served on the staffs of Jackson Park and Woodlawn hospitals and the old Washington Park Community Hospital.

Joseph Thomas O'Neill*, 69, pediatrician of Ottawa, and immediate past president of the Illinois State Medical Society, died in Billings Hospital, Chicago, February 25.

Dr. O'Neill was born in Boston in 1892 and was graduated from the Chicago College of Medicine and Surgery, predecessor of the Stritch School of Medicine of Loyola University, in 1916. He served as a lieutenant in the Army Medical Corps and after World War I began general practice in Joliet. Because of his love of children he later went to Europe for postgraduate courses in pediatrics and in 1927 opened an office in Ottawa to practice his specialty. He continued to live there as a beloved citizen until his death.



Dr. Joseph T. O'Neill

Dr. O'Neill had long been an active participant in society affairs. He had served on the Council since 1948 and was its chairman in 1955 and 1956. This past year he had been chairman of the Permanent Home Committee and the Committee to Study Postgraduate Education, in addition to being Councillor-at-Large for the Society. He was one of the original members of the Committee on Maternal Welfare when it was formed 28 years ago and was a member of the Nutrition and the Journal committees for over a decade. He was also on the Educational Committee in 1952, 1954, and 1956, and on the Finance Committee in 1951.

He was president of the La Salle County Medical Society in 1942-43 and in 1960 was a delegate to the American Medical Association, succeeding several years as an alternate delegate.

For the past two years he had been a member of the Blue Cross-Blue Shield essay committee which judged high school student compositions on subjects related to medicine.

Dr. O'Neill had been public health officer and school physician in Ottawa and was also a member of the American Legion, the Elks, and the Ottawa Boat Club.

Leon S. Seidler*, Chicago, a graduate of the University of Illinois College of Medicine in 1913, died January 7, aged 70. He was on the staff at Michael Reese Hospital and had practiced in Chicago for 46 years.

Charles O. Shallet*, Chicago, a graduate of Northwestern University Medical School in 1926, died January 31, aged 64. He had practiced in Chicago for 34 years.

Ralph D. Sullivan*, Chicago, a graduate of the Stritch School of Medicine of Loyola University in 1940, died January 16, aged 47. He was a member of the staff of St. George Hospital and an examining physician for the Selective Service System.

Victor Darwin Thomas*, St. Louis, Mo., a graduate of the Jenner Medical College in 1902, died December 6, aged 84. He was a member of the 50-Year Club of the Illinois State Medical Society, of which he was an Emeritus Member. He had been a resident physician at St. Mary's of Nazareth Hospital and assistant physician at Peoria State, Buffalo State, Greystone Park State, Terrell State, and Whitfield State hospitals.

Harry I. Van Tuyl, Hinsdale, a graduate of Northwestern University Medical School in 1898, died October 10, aged 91. He was professor and chairman of the department of anatomy at Northwestern's Dental School.

Lucius W. Wimby*, Chicago, a graduate of the University of Chicago School of Medicine in 1942, died January 8, aged 43. He was vice chairman of the medical department at Provident Hospital, and a member of the Prairie State and National Medical societies.

Edward C. Wrightsman*, Chicago, a graduate of the Northwestern University Medical School in 1905, died January 11, aged 80. He was on the staff of South Chicago Community Hospital. He had practiced in Chicago since 1905, and was a fellow of the American Medical Association.

William M. Yockey*, retired, Decatur, a graduate of Rush Medical College in 1891, died January 7, aged 92. He retired in 1940.

**Indicates member of the Illinois State Medical Society.*

BOOK REVIEWS



Occupational Diseases and Industrial Medicine. Rutherford T. Johnstone, M.D., and Seward E. Miller, M.D. $12. Pp. 482. Philadelphia, W. B. Saunders Company, 1960.

This is a completely new text and bears little resemblance to the 1948 edition by the senior author. In the twenty chapters the authors cover every aspect of industrial medical practice in a well organized, logical manner. The administrative, social, welfare, insurance, rehabilitative, and employee adjustment phases are presented following an introductory chapter on the scope and organization of medical services in industry. With this background, the authors in Part II devote thirteen chapters to specific occupational diseases covering gases, solvents, dusts, bacterial diseases, metals, resins, propellants, pesticides, physical agents (vibration, noise, compression, heat and cold, light and the electromagnetic spectrum, radiation). Supplementing this replete schedule is a table of the 1960 Threshold Limits for Toxic Gases and Dusts, including the latest recommended additions. A fifteen page glossary of industrial terms and eighteen page subject index complete the text.

The format, edition size, print, and the smooth, low reflective paper make a readable, enjoyable, usable volume. The task of condensing the many facets of industrial medicine to a small volume while retaining a sense of completeness with little omission is well done. This speaks well for the ability and practical experience of the authors, both of whom are internationally known both in the specialty and as teachers.

The editing has been meticulous, as one would expect of the authors, and very few errors were noted. I would prefer that Shavers' disease be covered in all aspects in one section rather than have the radiologic, clinical, and pathologic aspects in widely separated insertions. Siderosis and other exposures in welding are not included in the text. Dermatitis is mentioned as it occurs in some specific exposures but is not formally presented in a specific chapter. Antimony and arsenic are presented as metals and metalloids with only a chapter reference to the gaseous compounds, stibine and arsine, and no reference to the inclusion of arsenicals with the insecticides. However, the isolated contextual insertions have merit, and brevity of the edition precludes perfection. The chapter on the pneumoconioses covers a controversial area and arouses questions on the part of a reviewer; however, looking back objectively, the authors have given a good summary.

In fact, the whole field of medicine in industry is excellently presented in a series of brief reviews. The volume gives a good general picture of the field, yet is detailed enough to be a good reference text. This book must be on the reading shelf of any physician with industrial contacts.

Eugene L. Walsh, M.D.

Fundamentals of Chest Roentgenology. Benjamin Felson, M.D. $10. Pp. 301. Philadelphia & London, W. B. Saunders Company, 1960.

This is a short textbook of x-ray diagnosis which attempts to solve most of the diagnostic problems of chest disease utilizing fundamentals and discussing specific disease entities only insofar as they illustrate or are illustrated by the principles presented. These fundamentals are twenty-five special signs which the author states he has borrowed. He especially credits Dr. Felix G. Fleishner, "whose understanding of the complexities of this field is truly profound."

The roentgen work-up by means of fluoroscopy and necessary films is covered first. There follows a detailed explanation of the two main signs: the silhouette sign and the air bronchogram as a means of detecting and localizing even subtle chest lesions. The author covers lobar and then

segmental anatomy and variations and then includes a discussion of the hili, vessels, and lymph nodes before going on to the pleura, extrapleural space, and diaphragm, including hernias. He concludes by describing some additional signs of value in chest x-ray diagnosis and then tabulates the normal roentgen findings in 18,000 normal chest roentgenograms with regard to: level of hilar shadows, length of aorta, tracheal deviation, cardio-thoracic ratio and calcification, to mention but a few.

In addition to a bibliography at the back of the book which thoroughly covers the subject matter, there is inclusion of bibliographic references in the legends beneath some of the photographic reproductions.

The purpose of the book is to describe and explain the several signs which have been shown to have important diagnostic implications in chest x-ray interpretation. This is accomplished with ease by this recognized radiologist as he presents this material. He has done this for some time as a refresher course for members of his specialty at one of their annual meetings and then as joint author along with fifty specialists in a book which presented a short version of the material presented here. A review of the medical literature shows that Dr. Felson has written considerably in his field of interest, the chest and especially the lung.

The numerous photographic reproductions are of excellent quality, well chosen, and clearly labeled. They number 450 on 238 figures in 270 pages of text. A single column format is used for this compact book. The index is adequate, and the text amplifies the illustrations nicely.

This book will be enthusiastically received by radiologists and their residents, and by teachers of medicine and especially chest specialists. It is just as enthusiastically recommended for them and any others who are placed in the position of interpreting chest films.

William E. Bundesen, M.D.

Outline of Pathology. John H. Manhold, Jr., D.M.D., and Theodore E. Bolden, D.D.S. $4.75. Pp. 340. Philadelphia, W. B. Saunders Company, 1960.

As with most outlines, this book consists of series of definitions of diseases followed by some, though brief, discussion. Where present, the elaboration includes pathologic physiology and some microscopic descriptions.

The nature of the book is well described in the preface, "a relatively thorough treatment of basic pathologic processes" and "only the more specific attributes of the basic processes as they apply to the organ systems." It is complete in that it covers most disease entities. In the reviewer's opinion, such topics as plague, bejel, bizarre infections could be replaced by a mention of arsenic and boric acid poisonings as well as further development of trauma and radiation reaction.

The portion dealing with organ systems covers the important pathologic aspects and is satisfactorily concise in this analysis.

Certainly, the outline fulfills the purposes of the authors and can be used as a basis for study as well as a repeat survey.

M. C. Wheelock, M.D.

The Office Assistant in Medical Practice. Portia M. Frederick and Carol Towner. $5.25. Pp. 407. Philadelphia, W. B. Saunders Company, 1960.

This handbook is the updated revision of one by the same authors in 1956. The text deals exclusively with physician assisting — the earlier edition included dental assisting — and details latest equipment and procedures.

The book is divided into two major sections. The first deals with business and secretarial aspects; the second, with medical phases of office assisting. Equipment and procedures with which every assistant should be familiar are illustrated. Typical is the instrument set-up for particular physical examinations.

There is something of value for each member of the medical team in this book. It is a refresher in professional routine for the nurse and technician. It provides excellent instruction in current business and clerical procedures. Some front office activities discussed are reconciling a bank statement, use of the simplified insurance forms, and cyclical billing. Cyclical billing is alphabetical group billing — e.g., A's billed first day of the month, B's the second day, etc. Special emphasis is given to the importance of good public relations between personnel in the doctor's office and the public.

The medical secretary may gain a better knowledge of assisting in the examination room —

if ever she is called upon to do so. The text may also serve as a check on her secretarial and public relations performance. Medical secretaries employed by physicians who do research, lecture, or teach will find the special chapter on library and editorial duties most helpful. Included is instruction for preparing a manuscript, gathering information for abstracts, and how to use the library.

The "one-girl" office assistant and the high school graduate with no professional training will find every aspect of medical assisting discussed in an interesting and easily understood manner. Of primary importance are chapters dealing with appointment scheduling, the right kind of patient reception, and the do's and don'ts of telephone techniques. This is a valuable book to have in the doctor's office for handy reference.

Even the doctor who has or plans to have medical aides in his office will learn what clerical and semi-professional duties are ordinarily delegated to medical assistants and how to adapt these to his type of practice. It may also assist the physician in outlining office duties for employees and save hours of his time.

The authors, Portia M. Frederick and Carol Towner, are authorities in the field of medical assistant teaching and medical public relations. They sum up the objectives of their book in these words, " . . . to establish higher standards of efficiency among women employed as medical secretaries and assistants, and to inspire these women to render honest, loyal and more efficient service to the profession and to the public which they serve." These words were taken from the objectives of state medical assistant associations belonging to the American Association of Medical Assistants.

Caesar Portes, M.D.

The Management of Fractures and Soft Tissue Injuries. The Committee on Trauma, American College of Surgeons. $5. Pp. 372. Philadelphia, W. B. Saunders Company, 1960.

Why there should be a disassociation of treatment for soft tissue and skeletal injury has never been clear. Serious errors are committed when one system is cared for without regard or knowledge of other systems. The Committee on Trauma has combined their two excellent monographs into one volume, unifying the care of the injured patient.

Each section has been reworked and in certain instances rewritten. The principles and recommendations for treatment are presented in a concise, thorough manner. The chapters can be read with facility, and there is a liberal sprinkling of illustrations to augment the text. Immediate care, transportation, work-up, and method of treatment of the acutely injured person can be gleaned from its pages.

It must be recommended to the surgeon dealing with trauma and should be available to house staff members in every hospital emergency room. The volume makes a fine gift for a resident surgeon.

W. B. Stromberg, Jr., M.D.

Measure of success

What is success and how may it be judged? Alan Seeger has said, "Success in life means doing that thing than which nothing else conceivable seems more noble, or satisfying or remunerative." For every man there is a guiding star of ambition, — a secret and sometimes unrecognized heart's desire. Just as the personality and abilities of one person differ from those of another, so does this heart's desire differ for one and another, and progress toward fulfillment of one's desire represents success in one's chosen field; indeed success may truly be said to lie in the wholehearted effort one makes to attain that desire, for few achieve complete fulfillment. *Edwin H. Lawson, M.D. Success in Medicine. South. M. J. December 1960.*

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Literature on request

CENTRAL

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Hypertension in Israel

It can be seen that there is a greater prevalence of diastolic hypertension, and of the ageing process as seen in the retina, among the Yemenites who have lived in Israel for over 25 years as compared with Yemenite new immigrants who have not lived for more than 10 years in the country. The findings parallel the differences in the prevalence of diabetes, and in the blood-cholesterol and blood-phospholipids estimates between both groups, and confirm the impression that cardiovascular disease and arteriosclerosis are more prevalent in the settled group.

There is a great difference between the conditions of life in Israel and in Yemen, and there is little doubt that the different prevalences of hypertension and involutionary sclerosis between the two groups is the result of these differences. The lack of intermarriage with other groups of Jews eliminates constitutional and genetic factors as an explanation of the differences. The main differences between the two groups are in food habits and in the general strain of living to which they are exposed. The latter can be best described as the ambition for a higher standard of living, and the general "speeding-up" involved in the Western style of culture. *Daniel Brunner, M.D., et al. Myocardial Infarction among Members of Communal Settlements in Israel. Lancet. Nov. 12, 1960.*

The English GP

It is our particular good fortune to belong to medicine when it is again changing, or to be accurate has just changed. The increase of knowledge has enforced specialization—which itself ensures that knowledge will continue to grow at speed. But, because in Britain no one now lives far from a specialist, the general practitioner is prevented from doing much of the therapeutic job he was trained for. Instead, he is left with an overwhelming amount of other problems of diagnosis, treatment, and prevention of disease, for which he was not trained. He must transfer many patients to the care of another doctor, and he must be sure that he chooses the right specialty. *John Ellis, M.D. Preparation for the Profession. Lancet. Nov. 12, 1960.*

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The educated patient

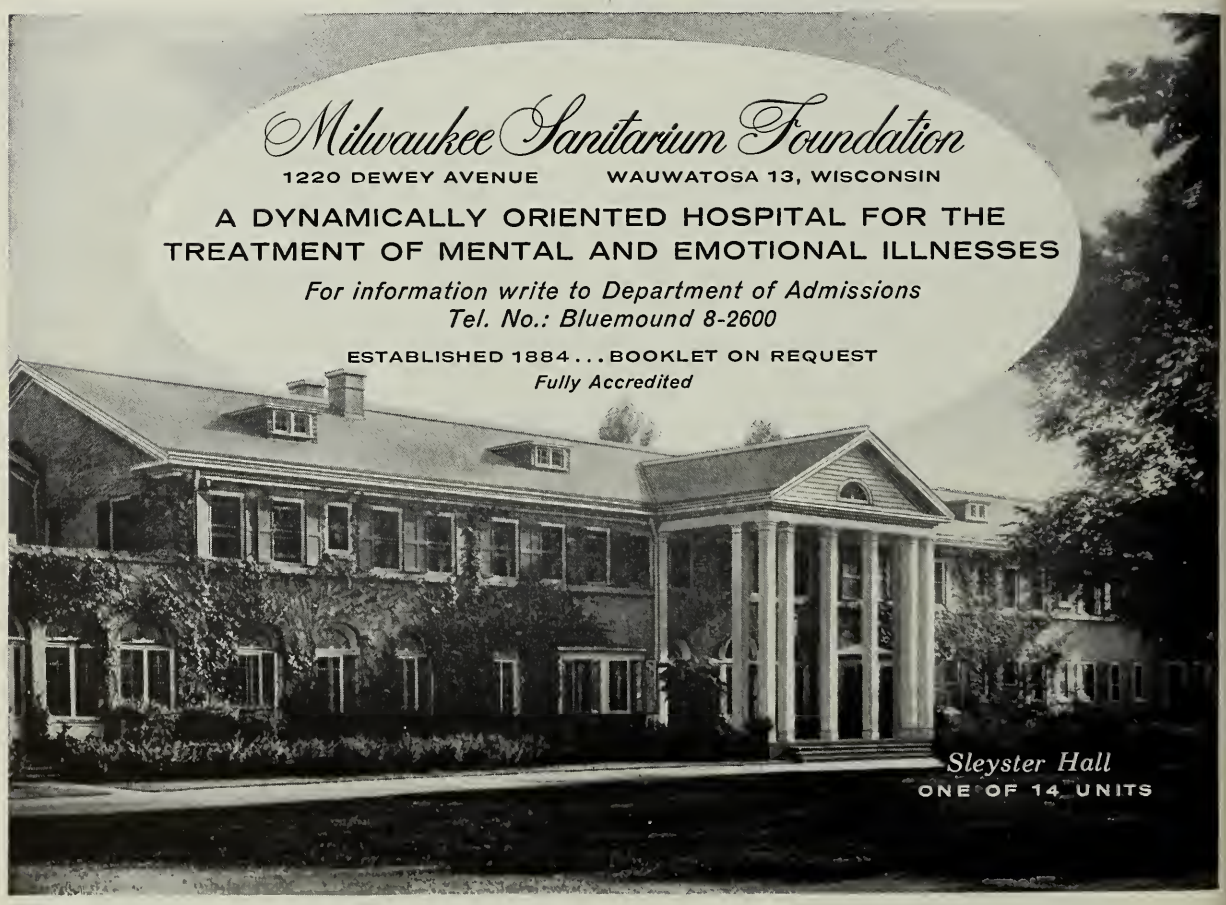
There is a mystery about books on illness. Many doctors refuse to let their patients read them. They say that the more ignorant among them are bewildered by the medical terms, and feel that they are worse than is the case. I feel that there is something in this, but very often the doctors are rationalizing and refuse to give information for the unconscious reason that their magical — or, in modern style — scientific power will pass away with the patient's knowledge. But knowledge is nearly always better than ignorance for anyone — for patients as for doctors. The known, however bad it is, is nearly always better than the unknown. The patient, knowing what is the matter with himself, can help the doctor on his symptoms. He can keep a cool head instead of a mind nearly panic-stricken with the unknown. His calls on the doctor are less frequent, and he is far less prone, instead of more inclined, to hypochondria. *Douglas Ritchie. Stroke. Faber and Faber, London, 1960.*

It is part of the cure to wish to be cured.

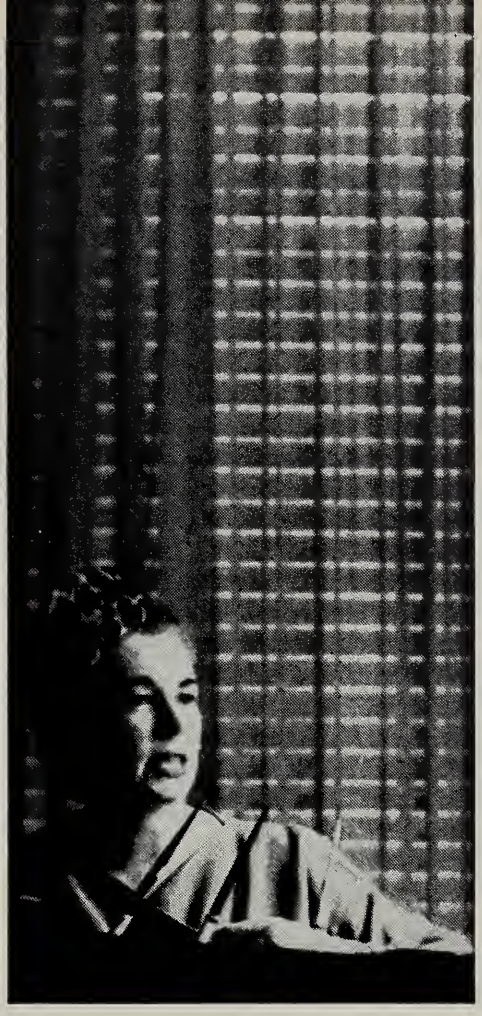
—*Seneca*



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Sober-up in a hurry

An investigation of the use of thyroid hormone L-tri-iodothyronine in the management of acute alcoholism has shown this agent to have a prompt sobering-up action when given intravenously in a total dosage of 200 microgm. Among 12 patients who received this treatment and were compared with 8 untreated, acutely intoxicated controls, the following results were obtained: the rate of blood alcohol decline averaged 15.0 mg. per 100 ml. per hour in the controls and 32.1 mg. per 100 ml. per hour in the treated patients; patients given the hormone were judged to be clinically sober and able to give a rational medical history within two hours after the injection; the odor of alcohol was undetectable on the breath two hours after treatment, although it persisted for six to ten hours in the untreated controls. Intravenous therapy appears to be a valuable adjunct in the treatment of acute alcoholism, particularly when such a patient is admitted to the hospital in a stuporous or semicomatose state secondary to severe intoxication and is unable to give a coherent medical history. *Marshall Goldberg, M. D., et al. Intravenous Tri-Iodothyronine in Acute Alcoholic Intoxication. New England J. Med. Dec. 29, 1960.*

Over emphasis in surgery

At the moment, too much emphasis is being placed on cardiac surgery to the neglect, I am afraid, of many other problems which are of equal importance to the patient and which occur with much greater frequency. No doubt this situation will correct itself once the newness and glamour begins to subside, though meanwhile too many young men are specializing in this branch of surgery, considering the demands for future needs and the responsibilities most have incurred to provide for their families. Someone has remarked that soon there will be more cardiac surgeons than cardiac patients. *Joseph E. Strode, M.D. The Surgeon's Responsibilities. West. J. Surg. November-December 1960.*

The truest mark of being born with great qualities, is being born without envy.

—*La Rochefoucauld*



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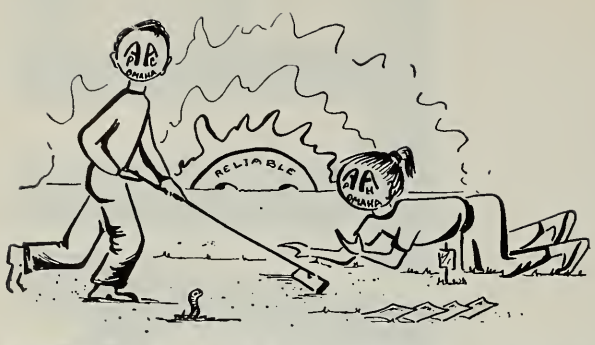
Indications: duodenal ulcer; gastric ulcer; intestinal colic; spastic and irritable colon; ileitis; esophageal spasm; anxiety neurosis with gastrointestinal symptoms, and gastric hypermotility.

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The hospital in medical practice

The parties to the Iowa litigation arrived at a compromise agreement which was subsequently enacted into law. This law expressly provides that radiology and pathology services performed in hospitals are medical services which must be billed and paid for as such. It provides that hospitals will not interfere with the medical acts and decisions of the physicians. At the same time, the law does recognize the standing of the hospital as the "third party" by authorizing it to maintain facilities for the services and by giving it an equal voice in the employment of technicians and in the establishment of fees.

There is reason to hope that in Iowa, at least, the conflict has been resolved in a way that will preserve for medicine its dominant position in the doctor-patient relationship, but which recognizes the hospital as a benign third party, and that this relationship can be happily maintained so as to permit both medical and hospital services to realize their fullest possible potentials for the benefit of the most important person, the patient.

It is discouraging to note, however, that the American Hospital Association has produced and published a legal brief which argues that the corporate practice rule is an acceptable principle as applied to *profit-making* corporations, quacks, and charlatans, but that it should not be applicable as a means of preventing *non-profit hospitals* from practicing medicine. The underlying argument is that hospitals should dominate the entire health field, of which the practice of medicine is only a part, and that as hospitals are public-spirited institutions, they can better be trusted with the over-all health care of the patient than can the practicing physicians. This concept, which strikes at the essence of the "Three's a Crowd" principle, will be certain to encounter active resistance, should it be pressed by the American Hospital Association. *R. B. Throckmorton. J. Iowa State Med. Soc. December, 1960.*

Go make thy garden as fair as thou canst,
  Thou workest never alone;
And he whose plot is next to thine
  May see it and mend his own.

—*Robert Collyer*



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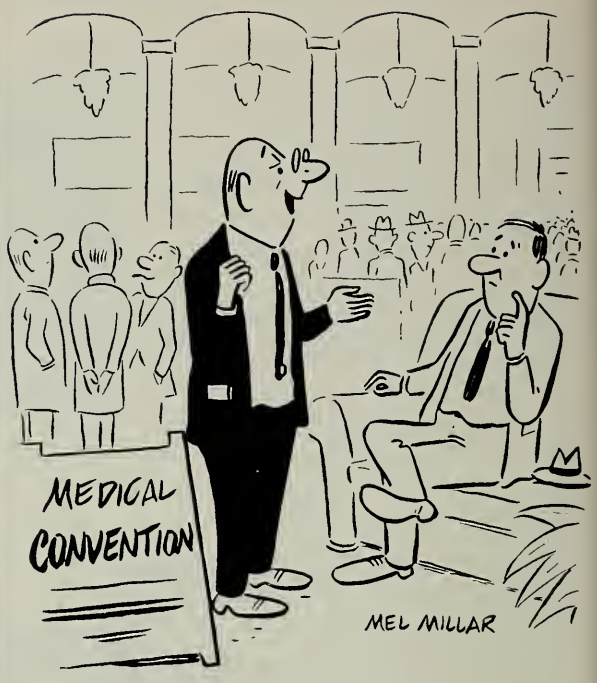
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The medical politician

Is it the so-called medical politician who is devoting his life to the training of future physicians? I say "so-called" because the term is a slanderous misnomer when applied to the physician who gives untiringly of his time and his interest to the furthering of professional activities through the medium of organized medicine. Politicians, according to dictionary definition, are primarily interested in political office or profit from them as a source of personal gain. This can in no sense be true of those who work through medical societies for the benefit of all the profession and for the public good. Recognition by one's colleagues is a personal gratification but cannot be considered the full measure of success in medicine. *Edwin H. Lawson, M.D. Success in Medicine. South. M. J. December 1960.*

No gain is so certain as that which proceeds from the economical use of what you already have.

—Latin Proverb



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Thus, the term "high-fat" diet is wrong; it should be "low-carbohydrate" diet. The obese patient loses weight on this diet, not because of some peculiar metabolism of fat but because of a reduction in calories. The implications of these findings are discussed in relation to theories of appetite control. *J. Yudkin, M.D., and M. Carey. Treatment of Obesity by the "High-Fat" Diet. The Lancet, Oct. 29, 1960.*

An idea, to be suggestive, must come to the individual with the force of a revelation.

—*William James*



We've just got time for a resolution castigating the American Medical Association . . . . the bar closes in 15 minutes.

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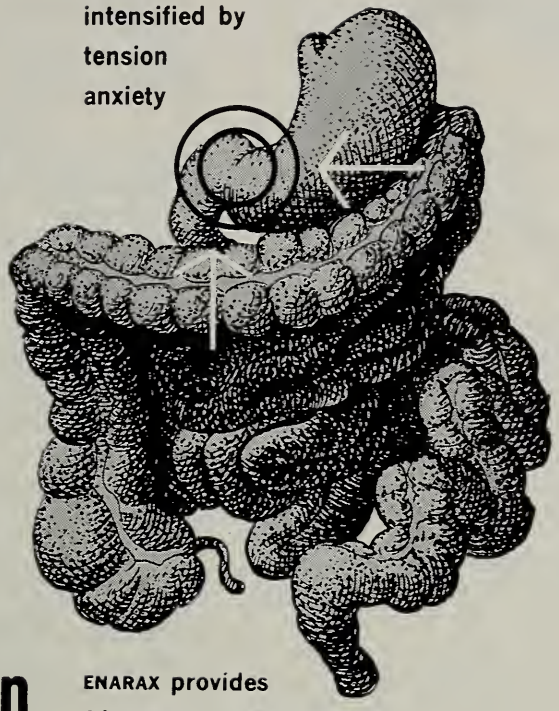
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References: 1. Hock, C. W.: Am. J. Gastroenterol. 34:293 (Sept.) 1960. 2. Leming, B. H., Jr.: Clin. Med. 6:423 (Mar.) 1959. 3. Data in Roerig Medical Department files.

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New emphasis on genetics

Genetics is rapidly finding its way into ordinary medical conversation. In the very recent past, the subject of genetics as applied to medicine was ignored and generally thought to possess a very nebulous and highly theoretical application for physicians in the actual practice of medicine. However, it is not unusual to pick up a current medical publication and find some aspect of this subject discussed. We are beginning to probe farther than the "X" and "Y" chromosomes. We are beginning to learn of the chromosomal character of cells. The chemistry of genetics is receiving more than a passing interest; as doctors we are becoming more concerned with the familial significance of a growing list of medical abnormalities. And as a sign of the times, the specialty boards are beginning to include questions on genetics in their examinations. So whether we like it or not, it looks as though we will have to familiarize ourselves with as much of genetics as we can absorb. *Thomas J. Marland, M.D. Editorial. Genetics—A New Medical 'Must.' J. Mississippi M. A. December 1960.*

Abstract of Council Actions

Meeting of March 12, 1961

COUNCIL SETS LEGISLATIVE PROGRAM

The Council made several legislative policy decisions. Some of these are:

SB 197 (Mills-Kerr) is to be given priority; HB 136 constitutes self-seeking legislation, does not deal with a substantial problem, is probably unconstitutional and should not be supported; HB 140 should be amended to at least require that non-citizens be able to read, write and speak English, and those non-citizens who become licensed should not be eligible for re-registration in the event that they do not perfect citizenship within a reasonable time; HB 155 does not deal with a substantial problem, is not needed, would duplicate existing services, and accordingly, the bill should be opposed; HB 226-227--naprapaths should be required to have the same high standards of other medical practitioners, and accordingly these bills should be opposed; HB 278 deals with the problem of unauthorized practical nursing schools and should be endorsed; HB 377 is referred to the Committee on Mental Health for evaluation and recommendation.

The Council approved a proposed bill to be offered to the Legislature designed to protect the confidentiality of tissue committees and maternal welfare committees in hospitals, and medical research designed to reduce morbidity and mortality.

NAME COMMITTEE TO MEET WITH OSTEOPATHS

Council approved the appointment of a committee to meet with a committee from the Illinois Osteopathic Association. The members of the committee are Drs. James H. Hutton, Chicago, chairman; Everett P. Coleman, Canton; Arthur F. Goodyear, Decatur; Caesar Portes, Chicago, with Mr. John W. Neal, special legal counsel, serving in an advisory capacity.

SPRINGFIELD NEWSLETTER TO ENTIRE MEMBERSHIP

Numerous councilors reported that the Springfield Newsletter has been an effective means of keeping the membership informed concerning legislative developments. Distribution to the entire membership was approved.

It was decided that the content should be factual. It will be edited by the Committee on Medical Service, and published under the sponsorship of the committee for distribution to all members.

CONTRIBUTION TOWARD MEDICAL ASSISTANTS MEETING EXPENSES

Upon the recommendation of the Advisory Committee to the Illinois Medical Assistants Association, Council voted to donate $200 toward the organization's annual meeting expenses. The committee paid a glowing tribute to the efforts of the working girls in offices of physicians.

ADMINISTRATIVE SEMINAR TO BE HELD MAY 15

Council approved the holding of an "Administrative Seminar" during the Annual Meeting Monday, May 15, beginning with a luncheon at noon and continuing until 4 P.M. Tentatively, it will include a speaker on "Motivational Research," one on the present picture of voluntary health insurance, and a debate on "Physicians Should Be Covered by Social Security." The latter is expected to be helpful since the question will be introduced in the House of Delegates by several county medical societies.

WILLIAMSON COUNTY MEDICAL SOCIETY COMMENDED

The Council commended the Williamson County Medical Society for passage of a resolution stating that all residents of the county are presently receiving adequate medical care under existing county and state programs regardless of their ability or inability to pay.

INSURANCE FORMS PROGRAM IS OUTLINED

The Committee on Prepayment Plans and Organizations recommended and the Council approved that:

(1) When a physician receives a form from an insurance company bearing the Health Insurance Council (HIC) symbol, it should be completed and returned to the company:

(2) When a physician receives a form not identified with the HIC, he should make use of the form approved by the AMA Council on Medical Service:

(3) If the insurance company insists on having its own form completed, the doctor should feel justified in making a reasonable charge for the additional work.

To implement this, the Council voted to send:

(1) A letter to every ISMS member outlining the recommended procedure with 100 forms included free of charge.

(2) A letter to the president of each county medical society, urging publicity and local support; this to be followed by an article in the Illinois Medical Journal.

NEW STATE DIRECTOR OF PUBLIC WELFARE INTRODUCED

Dr. Francis Gerty, the new director of the Illinois Department of Public Welfare, was introduced to the Council. Dr. Gerty said he had accepted his assignment on a temporary basis but that if he had a reasonable measure of success in having his program instituted he may remain. Meanwhile, he hoped a code department of mental health would be set up.

He pointed out that as presently instituted the Department of Public Health is involved with problems other than mental health and retarded children.

EMERITUS AND RETIRED MEMBERS ELECTED

Council approved emeritus status for Drs. J. Lawrence Hagan, Ralph Pagano, F. W. Rohr, and James P. Simonds, all from Chicago Medical Society; Corna L. Bennett, Vermilion County; Rudolph C. Heiligenstein, St. Clair County; Frederic J. James, Edgar County; Harry Logan, Marion County.

The following were elected retired members: Drs. Ferdinand M. Asma, Leslie G. Haupt, Beryl A. Ingalls, John D. Koucky, Morris P. Orloff, Ralph H. Warden, Alfred Wolfarth, all of Chicago Medical Society; Raymond Joseph, St. Clair County; Karl E. Manglitz, Jr., LaSalle County; Clarence A. Barnes, Lake County.

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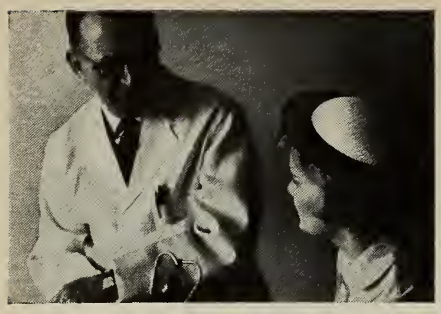
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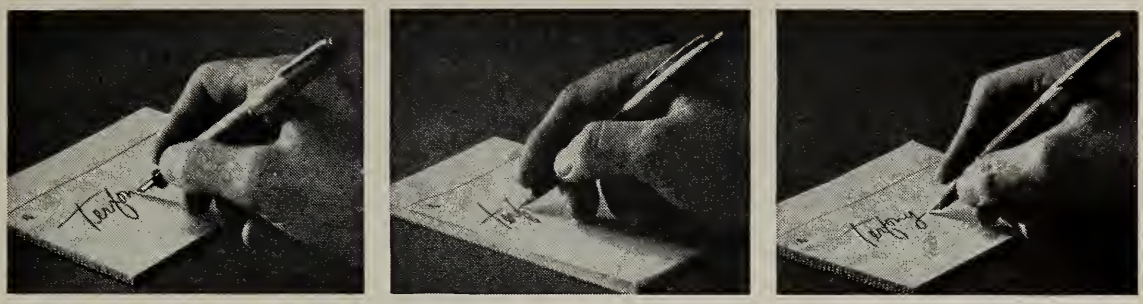
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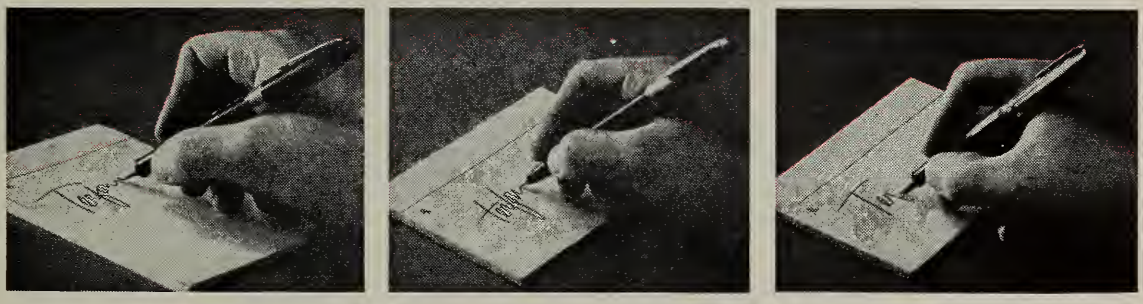
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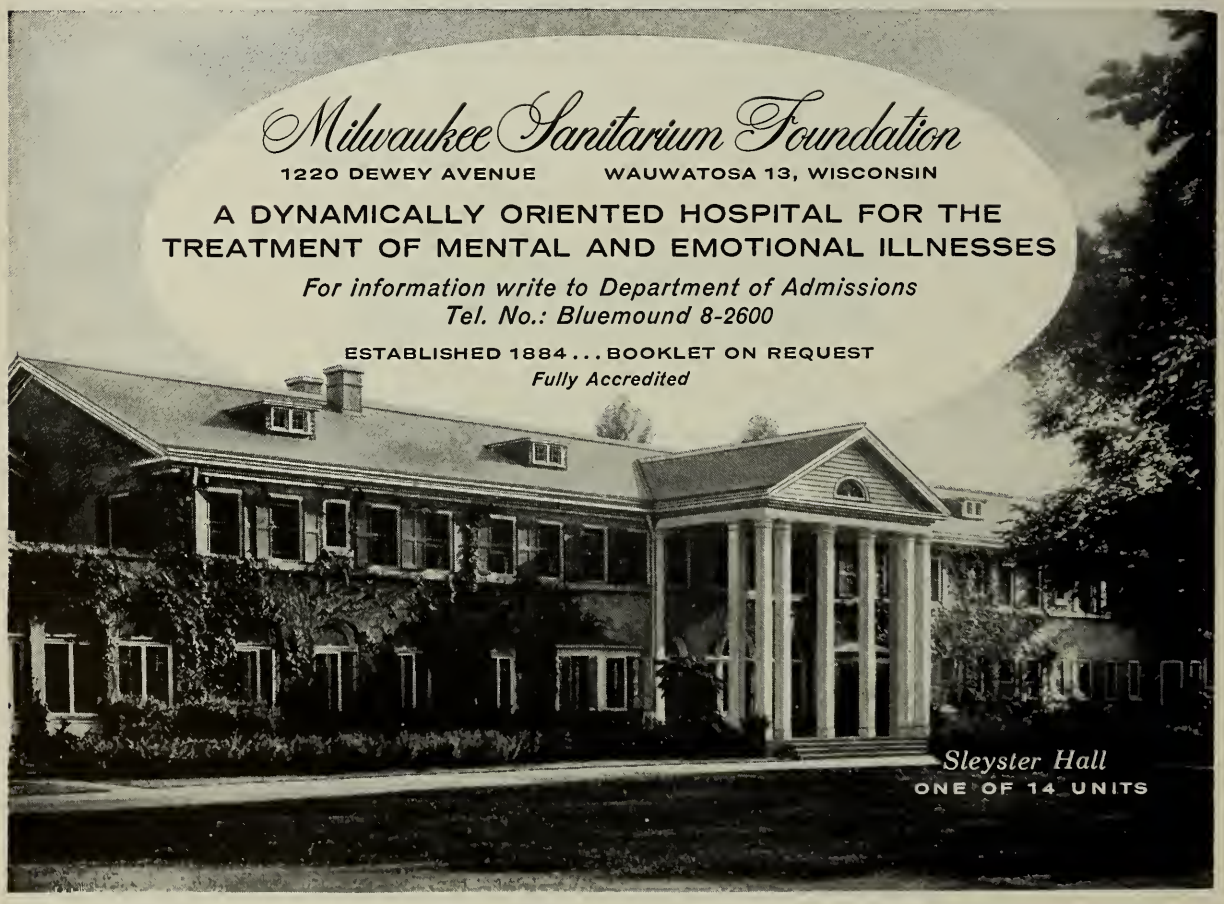
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The Month in Washington



The medical profession, the U.S. Public Health Service, and the National Foundation are working together in an all-out drive to get as many persons as possible to take Salk vaccine shots before the summer polio season starts. The Sabin live polio vaccine will not be available in quantity this year. The Salk vaccine campaign drive is directed particularly at children and younger adults in the lower economic groups.

Dr. Julian P. Price, Florence, S.C., chairman of the American Medical Association's Board of Trustees, pointed out that many children and younger adults in the lower income groups have not been inoculated against polio. "As long as 'islands of unvaccinated persons' exist even within well-vaccinated communities, polio epidemics remain a serious threat," Dr. Price said.

Dr. Luther L. Terry, Surgeon General of the Public Health Service, emphasized the need for immunizing infants. He also said that the PHS will encourage behavioral studies to determine reasons why some people refuse to take polio shots. It is hoped that then methods may be devised to overcome such refusal.

Dr. Terry called particular attention to the findings of the PHS's Advisory Committee on Poliomyelitis Control that the recommended dosage schedules may be modified to permit the administration of three shots of Salk vaccine before summer to persons who have not had any vaccine before.

Dr. Price stressed that success of the "babies and breadwinners" polio vaccine campaign depends on joint activity at the local level by medical societies, boards of health, and voluntary health agencies. He expressed confidence that the more than 2,000 state and county medical societies throughout the country would cooperate wholeheartedly. "Contrary to recent reports (in Scripps-Howard Newspapers)," Dr. Price said, "the AMA is strongly behind every effort to encourage the public to take advantage of the Salk vaccine without delay."

The Advisory Committee urged that "immediate steps . . . be taken by all interested groups to intensify drives for vaccination with the formalin-inactiviated (Salk) vaccine." The Committee also endorsed the plan to direct the campaign particularly at the lower socioeconomic and younger age groups.

The Committee recommended that the first available supplies of the Sabin live, oral vaccine be utilized in the following priority order; (1) Epidemic control, investigations and community studies; (2) Immunization of infants and preschool children; and (3) selected area immunization of those segments of the population that are least well immunized.

Congress now has before it legislation to carry out all of President Kennedy's broad health program, but it is doubtful that the lawmakers will act upon some of it this year. Kennedy health legislation sent to Congress recently included

(*Continued on page* 18)



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WASHINGTON (Continued)

bills on medical education and federal grants for nursing homes and other community facilities.

The Chief Executive also recommended an expanded program to combat water pollution. He requested Congress to authorize federal grants of $125 million a year for 10 years to help states forming interstate water pollution control agencies. He also recommended increased federal aid to communities building sewage treatment plants. The President proposed creation of a special unit in the Public Health Service to handle both air and water pollution matters.

In accompanying letters to the presiding officers of the House and the Senate, Kennedy said he regarded his medical education proposals as the keystone of the over-all health program because "we are not presently training enough (physicians) to keep up with our growing population." The other bill would "make possible a substantial addition to the number of nursing home facilities to care for long-term patients, and . . . help relieve the shortages of home health care programs," Kennedy said.

The medical education measure would authorize federal grants for scholarships for medical and dental students. Each medical and dental school would be eligible for a total of scholarship grants equal to $1500 times one-fourth of the enrollment after the program had been in effect for four years. The maximum individual scholarship would be $2,000 a year. Participating schools also would be eligible for federal grants of $1,000 per scholarship to help pay a school's operating expenses.

The community health facilities bill would increase the annual authorization for federal grants for construction of nonprofit nursing homes from $10 million to $20 million and raise the minimum state allotment from $50,000 to $100,000 per year. It also would broaden the PHS Surgeon General's authority to conduct research, experiments, and demonstrations on development and utilization of hospital services, facilities, and resources to include other medical facilities.

Federal grants also would be authorized to help finance studies, experiments, and demonstrations by states and other nonfederal agencies for development of new or improved methods of providing health services outside hospitals, particularly for chronically ill or aged persons.

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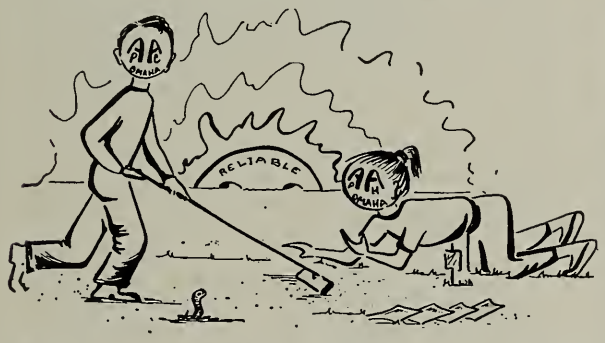
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nedy's over-all health program, but stood fast in opposing the proposal to provide elderly persons with health care through the social security system. Dr. F. J. L. Blasingame, executive vice president of the AMA, said; "We support the broad principles and the general goals of the President's program, but we cannot support his proposal for hospitalization and nursing home care for persons over 65 under social security. In fact, after studying this section of the President's plan, the AMA more strongly than ever reaffirms its support of the Kerr-Mills law."

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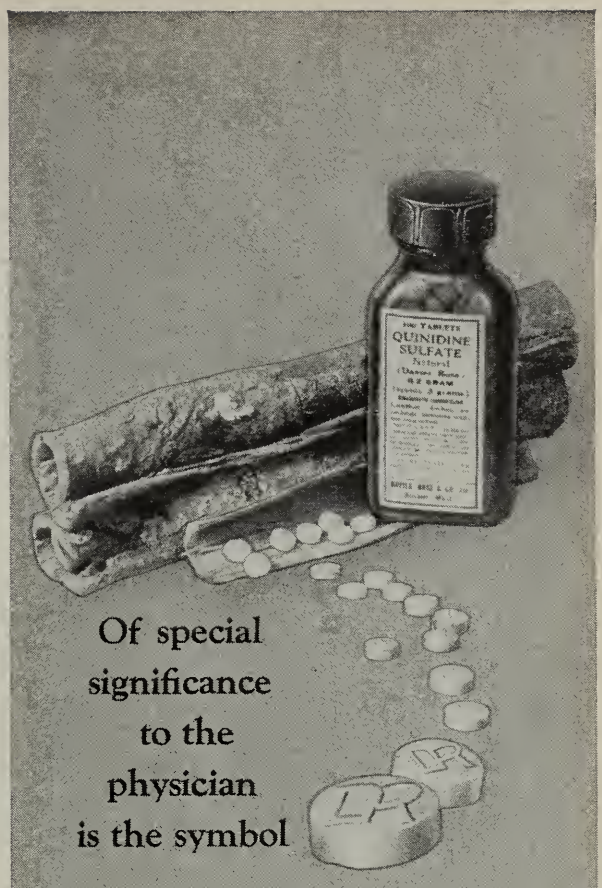
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Thromboembolic disease

It has been our strong impression that patients with a painful thrombotic process in the deep venous system of the lower extremities experience the fastest symptomatic relief with the intermittent intravenous use of heparin. Of course, it is difficult to assimilate unbiased data on this point in a retrospective study such as this. A more objective method of study would be to note the average number of days spent in the hospital by patients who are admitted to the hospital because of deep thrombophlebitis, and who have no other illnesses that might prolong the hospital course. We found 119 such patients who met these criteria, excluding those with a recent history of trauma and excluding 2 patients who signed out shortly after admission. The shortest average hospital stay, six and eight-tenths days, was achieved in 5 patients treated by venous ligation. Of those managed with anticoagulants alone, the shortest average stay was achieved in the group treated intravenously with heparin, eleven and two-tenths days, and the longest average hospitals stay in those treated with bishydroxycoumarin alone, twenty-eight and eight-



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tenths days. *Captain Charles H. Fuller, USAF, et. al. Management of Thromboembolic Disease. New England J. Med. Nov. 17, 1960.*

The negative view

This system of medicine which we all use, and which the student has to learn, is of great practical value and is as "scientific" as any other method of science. It is far more difficult than the planned isolated experiment, for it has to take what any patient happens to present. It has to deal with such a vast subject that the numbers of possible combinations make neat statistical results almost impossible to achieve. Thus today results show that arteriosclerosis and coronary-artery disease are due to saturated animal fats in the diet; that they are not due to these fats: that disseminated sclerosis is due to a virus; that it is due to allergy: that skin conditions are quite separate from emotional stress; or, as I personally believe, that they are closely related to emotional stress. *William Gooddy, M.D. Syndromes. Lancet. Jan. 7, 1961.*

Chance favors the prepared mind.—Louis Pasteur

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The ILLINOIS Medical Journal

Official Journal of The Illinois State Medical Society

APRIL, 1961
VOL. 119, No. 4

Evaluation and Treatment of The Multiple-Injured Patient

Irwin M. Siegel, M.D., *Chicago*

The multiple injury accident case has become common in the emergency room of even the smallest community hospital. The number of such cases would seem to be almost directly proportional to the increasing horsepower of the modern automobile. As this latter factor does not show promise of a decline, we can anticipate an increase in the former.

Often it is the staff or family physician who is first called to attend the multiple-injured patient. Regardless of the importance of seeking appropriate consultation in such cases, it is the initial evaluation and original treatment which determine the direction of the patient's future course and perhaps even his ultimate outcome. This original care may be the lot of any practicing physician, and it is wise to have well in mind an outline for evaluation and well in hand a program for life-saving therapy. It is the purpose of this paper to present such a method.

Orthopedic department, Strauss Surgical Group, Louis A. Weiss Memorial Hospital, Chicago.

Initial evaluation

There are three priorities of injury in a multiple-injured patient: (1) injuries interfering with vital physiological functions (i.e., flail chest); (2) injuries not imposing an immediate threat to life but if not amended, disastrous at a later time (i.e., perforation of a hollow abdominal viscus); (3) injuries which, though increasing morbidity, usually pose no threat, early or late, to life (i.e., closed fracture of a long bone).[1]

A sequential procedure for evaluation and treatment is of obvious importance.

Attention should be directed first to the early threats to life, treatment for wound shock initiated, and measures taken to assure resuscitation. After the patient has been stabilized, he may be re-evaluated for more obscure damage and attention directed to those injuries falling within the second and third priorities.

This evaluation should not only assess current injury but also detect pre-existent disease and establish base-line observations. Definitive surgery must await such evaluation.

In the systematic examination it is well from the outset to suspect and search for certain common injury patterns briefly presented here by system.

Cardio-respiratory

It is often necessary to reintegrate the vital processes of respiration and circulation; immediate attention must be given this problem when present. Adequate resuscitation, that is, the relief of cyanosis and the administration of blood and oxygen, assumes precedence over all other emergency needs. Bleeding into the chest must be controlled and the respiratory passages cleared of secretion. Emergency tracheostomy may be necessary. A flail chest wall should be stabilized and the pleural space freed of blood and air so that both lungs can expand. Debridement and dressing of external chest wounds can wait.[2]

One of the most demanding chest injuries is pneumothorax. This may be one of several types: tension, requiring water-sealed drainage, or open (secondary to a sucking chest wound and evidenced by mediastinal flutter), requiring closure of the chest wound. Paradoxical chest motion secondary to flail chest is remedied by stabilization of the chest wall.

Cardiac tamponade, usually secondary to steering column injury, demands urgent attention. Most prominent in its symptom complex are a narrow pulse pressure, tachycardia, a falling systolic blood pressure, paradoxical pulse, distended cervical veins, and muffled heart sounds. A needle inserted into the pericardial sac through the usual route at once confirms the diagnosis and establishes therapy.

Abdominal

To properly examine an abdomen for suspected injury, one must have some plan of approach.[3]

The abdomen houses four hollow viscera and seven solid viscera. Injury to a hollow viscus (the stomach, gallbladder, large or small bowel) is evidenced by the signs of peritonitis with tenderness, rigidity, rebound, and decreased or absent bowel sounds.

Injury to a solid viscus is evidenced by pain, tenderness, and abdominal rigidity in that area where the viscus lies — the liver in the right upper quadrant, spleen in the left upper quadrant, pancreas in the epigastric area, and kidneys or adrenals in the flanks.

Splenic rupture, either immediate or delayed, is one of the most common abdominal injuries. Left upper quadrant pain is present and may be referred along the phrenic nerve to the neck. Dullness to percussion in the quadrant is sometimes evidenced as well. Bowel sounds are decreased. The leukocyte count is increased, and an abdominal tap can reveal blood. Medial displacement of the gastric air bubble may be found on a flat plate of the abdomen. The treatment consists of surgical removal of the organ followed by the usual postoperative management.

Genitourinary

Post-traumatic flank pain and tenderness with associated flank mass and hematuria point to renal injury. The treatment is conservative unless bleeding continues. On the other hand, suprapubic pain and rigidity with inability to urinate suggest urinary bladder perforation, the treatment of which is never conservative. Cystography can aid in confirming the diagnosis, and operative exploration is imperative.

Urethral injuries are diagnosed by urethral bleeding, inability to void, pain, and perineal or scrotal mass if the injury lies distal to the urogenital diaphragm. Surgical repair with diversion of the urinary stream is usually indicated.

Central nervous system

A suspected central nervous system injury requires a thorough neurological evaluation. It is important to establish a base line of vital determinations from the moment the patient is first seen.[4]

Basal skull fractures may involve either the anterior, middle, or posterior fossae. Circumorbital hemorrhage would suggest fracture in the anterior fossa, whereas auricular hemorrhage suggests the middle, and mastoid hemorrhage the posterior fossa.

Central nervous system hemorrhage may be conveniently divided into extradural, subdural, and subarachnoid. Extradural hemorrhage is usually caused by a tear of the middle meningeal artery secondary to fracture of the temporal bone. Subdural hemorrhage is venous in nature, and the local signs of central nervous system pressure may develop slowly because of this. A bloody spinal fluid tap and meningismus are present with subarachnoid hemorrhage.

Musculoskeletal

In evaluating orthopedic injury one must remember that the most serious fractures in the multiple-injured patient are those of the vertebral column, particularly the cervical spine.

The status of the vertebrae must be established before any attempt is made to position or move the patient. Fractures should, of course, be splinted and compound injuries dressed until definitive care can be given. In evaluating bony injury one must not "miss the forest for the trees" by forgetting that a fractured pelvis is often the cause of a genitourinary injury, fractured ribs may puncture lungs, and jack-knife compression fractures of the spine are often associated with fractures of the os calci.

Summary

The multiple injury accident case presents a challenging problem in diagnosis and treatment. To expedite the care of such patients, a sequential procedure of examination and treatment is necessary. Those injuries posing immediate threat to life should be sought and given emergency attention. A routine system of examination that assesses the patient system-wise is best as the physician searches for frequently occurring injury patterns.

After the patient has been adequately resuscitated and base-line observations made and recorded, he can be re-evaluated for more obscure and less life-threatening injuries. Definitive surgery must await stabilization of the patient and reintegration of his vital processes.

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Diet and Atherosclerosis

B. L. Martz, M.D., *Indianapolis*

Several research leads are currently of interest in efforts to prevent the clinical manifestations of atherosclerosis. Much emphasis is being placed on studying the clotting mechanism, the possible etiologic role of "stress and strain," the role of various levels of physical activity on atherosclerosis, and the possible effect of a diet high in saturated fat. Providing leadership in an effort to alter the American eating pattern appears to be the most effective prophylactic program for the physician today.

Certainly the value of restriction of saturated fats in preventing or reversing atherosclerosis has not been proven conclusively. The evidence, however, is becoming more convincing that the level of circulating lipids — usually well correlated with the measurement of serum cholesterol levels — is an important etiologic factor in the extent of atherosclerotic lesions in man. In the animal kingdom man distinguishes himself by consuming the most fat calories and by maintaining the highest plasma cholesterol level. The relationship between these observations and the high incidence of disease related to atherosclerosis is more suggestive of cause and effect than are many of the other precepts upon which we base therapeutics.

It is frequently stated that getting patients to follow a low fat diet is so difficult that efforts in this regard are pointless. No such reluctance has been observed in the prescribing of homeopathic doses of unsaturated fat preparations or other therapy less disturbing than diet to the patient's "way of living." These non-dietary approaches represent closing our eyes to the obvious and most rational attack against hypercholesterolemia — namely, dietary restriction of saturated fat. Such therapy usually represents a drastic change in methods of cooking and in eating habits, and may be quite disturbing to the patient at the onset. Physicians must take an interest in exploring ways of making this regimen more acceptable.

As emphasized by the authors of one book on low-fat cookery,* "the problem of decreasing fat in the diet can be moved out of the dining room into the kitchen." We must stimulate an interest in a new mode of food preparation that will match the demands of palatability. Group instruction by dietitians and exchange of recipes and experiences among patients are helpful techniques, but certainly a necessary ingredient is salesmanship on the part of the physician.

If an excessively high intake of saturated fat is an important factor in the high incidence of atherosclerosis in this nation, it may require more than a generation to modify eating habits to the necessary extent. The hypothesis of the genesis of the atherosclerotic plaque that relates it to the fatty intimal streaks of childhood would suggest that these dietary alterations, if they are to be of value, must begin early in life. This again emphasizes that the key to this prophylactic approach is a different mode of food preparation from that resulting in the meals of fat-rich meat, gravy, dairy products, and desserts which made "grandma's table" so memorable.

It may be decades before the validity of this dietary approach is fully assayed. However, the stakes are so high that we should not wait until overwhelming evidence is obtained but should risk committing a minor error in the direction of unnecessary dietary restriction rather than the alternative of passive acceptance of our atherosclerotic fate.

Marion County General Hospital, Indianapolis, Indiana.

While the Nutrition Committee of the Chicago Heart Association is sponsoring this article, the opinions expressed are those of the author and do not necessarily represent the official view of the committee.

*Stead and Warren: Low-fat Cookery, New York, McGraw-Hill, 1959.



Cook County Hospital

Chronic Abdominal Pain

Moderator:
ROBERT J. FREEARK, M.D.
Director, Department of Surgical Education
Cook County Hospital

Discussants:
EDMUND F. FOLEY, M.D.
Clinical Professor of Medicine, University of Illinois College of Medicine; Chairman, Department of Medicine, Cook County Hospital
FRANCIS H. STRAUS, M.D.
Clinical Professor of Surgery (Rush), University of Illinois College of Medicine; Attending Surgeon, Presbyterian-St. Luke's Hospital

Dr. Robert J. Freeark: The selection of so vague a subject as chronic abdominal pain for this morning's conference is a reflection of several recent experiences with this problem on the wards of Cook County Hospital. Patients similar to the one we will present today are infrequently admitted to a large charity hospital. The absence of objective findings is often a basis for referral to an outpatient clinic rather than hospitalization and thorough diagnostic study. Often the house staff comes to expect positive and absolute findings in patients with disease, and their absence is often construed as manifestations of psychoneurosis or malingering.

Yet such patients make up a large percentage of the practice of medicine. By knowing the highly varied symptomatology of organic disease, the wise clinician will recognize from subjective complaints alone the existence of a pathologic state requiring treatment. In essence, this is the problem of chronic abdominal pain. It refers to the patient whose symptoms seem genuine; yet examination and diagnostic study are unrewarding in search for the cause.

Our discussants today are men of proven merit in the baffling and frustrating problem of recurrent abdominal discomfort. We are hopeful that their years of experience will provide us with some insight into the management of these cases. Dr. Foley will serve as our guest because he is an internist and is chairman of our department of medicine. Dr. Straus is not really a guest; he is a member of the consulting staff and, being right across the street at Presbyterian-St. Luke's Hospital, we consider him one of our own surgical team.

Case Report

Dr. Ralph Bransky, surgical resident: A 25 year old Negro man was admitted to Cook County Hospital in November, 1959, with a history of intermittent epigastric pain and postprandial emesis present since 1958. On previous hospitalizations three upper gastrointestinal series had been negative. Work-up in November demonstrated a gastric ulcer seen at gastroscopy, and the patient was discharged on medical therapy. His symptoms persisted, however, and he was readmitted in February, 1960. Intravenous pyelogram and retograde pyelography, performed in pursuit of the cause of transient costovertebral angle tenderness were negative. Repeat gastroscopic examination was reported normal. While on the ward on strict ulcer management, the patient continued to have intermittent epigastric pain and frequent postprandial emesis.

Partial relief of pain was achieved by continuous nasogastric suction, and even more relief was obtained by ice water instillations into the stomach. Free acid was present in all gastric aspirates obtained and was usually greenish in color.

About three weeks after admission and while on ulcer management, the patient developed epigastric tenderness in addition to the previous complaints. Two days later abdominal exploration revealed a questionably deformed duodenal bulb and a "narrowed pyloric canal." He underwent vagotomy and one-layer Heinecke-Mickulicz pyloroplasty, following which he did well until the eighth postoperative day when an episode of postprandial emesis occurred. On the eleventh postoperative day a gastric analysis showed no retention, hypoacidity in the fasting state (10 clinical units), and normal response to histamine (maximum 52 units). He was discharged thereafter and, while followed as an outpatient for the past eight months, has had frequent episodes of his old complaints, despite reinstitution of medical therapy.

Although his pain was relieved by Amphojel® and food, the severity and frequency of painful episodes as well as frequent emesis provoked return to the hospital in October, 1960. While observed on the ward, he had frequent emesis of most of his food, and complained often of periumbilical pain which radiated to all abdominal quadrants and to his back. An upper gastrointestinal series showed no clear-cut ulcer, and there was no evidence of delayed gastric emptying. A 12 hour gastric aspiration returned 500 ml. of greenish liquid with 20 units of free acid present. His symptoms were largely relieved by endogastric suction. Despite statements that only liquids were being tolerated orally, the patient never demonstrated urinary concentration, ketosis, dehydration, nor marked weight loss. He was discharged from the hospital early in November on Urecholine®, and is being followed in the clinic.

Discussion

Dr. Freeark: Considerable effort was expended in an attempt to assess the functional aspects of this man's discomfort. Limited contacts with the family and friends were not instructive concerning his emotional life. He appeared to be happily married, had three children and a good job. He sleeps well in spite of gastrointestinal disturbance.

I have alerted our discussants to the fact that we do not have the answer to this patient's problem, and we are fully aware that the evaluation of such a patient requires the assessment of many factors that cannot be outlined on a protocol. Both Dr. Foley and Dr. Straus have talked briefly with the patient before this session started, and I am sure they will emphasize the importance of this. We would like to have Dr. Foley begin the discussion and give us his impression of cases such as this, and tell us what he has seen that will befuddle the surgeon—both before and after operation—in the way of chronic abdominal pain.

Dr. Edmund F. Foley: You might better have asked me for comments about cases in which we have been befuddled and, therefore, called the surgeon. Competent surgical consultation is a valuable asset in this chronic abdominal pain situation because so many things masquerade as bellyache. While customarily and traditionally the causes of chronic abdominal pain have been classified on an etiological basis, it is often of greater help to divide the cases into groups which are based upon what the patient tells us. What do we hear from a patient with chronic abdominal pain?

The first group to consider is the patient with the constant bellyache. Constancy of the pain usually means that there is something that is expanding. This is what you see in neoplastic disease which is rapidly progressing. Constant pain is produced also by any sort of accumulation of fluid under pressure, like an abscess or hematoma. On occasion a similar pain is produced by a slowly progressive accumulation, such as in tuberculous peritonitis or in a girl sitting up in bed with her knees pulled up to her chest, the girl with acute gonorrheal salpingitis. These are causes of a constant type of pain. When you ask such a patient how his pain is, he says that it never goes away, that his bellyache is constant. Hearing this, you can be sure it is due to something that is expanding under pressure, unrelenting and ruthless.

The second type of pain we might call a remittent pain, one that comes and remits. One of the first that comes to mind is the pain of chronic relapsing pancreatitis. Another remitting or re-

lapsing pain is encountered with stones or foreign bodies. The pain has a tendency to remit whenever a stone or a foreign body cannot pass a tube like the ureter or the gallbladder. We have a remitting pain also in the person with a penetrating ulcer in the second portion of the duodenum. This is an entirely different entity clinically, symptomatically, and therapeutically from the ordinary ulcer in the first portion of the duodenum. Instead, it acts much like relapsing pancreatitis and is characterized by periodic exacerbations of painful episodes.

The third type is the periodic chronic pain. First was the constant type, second the remitting type, and third the periodic pain. The periodicity is both in terms of months or weeks apart and periodically during the day. Periodic pain is always related to disturbance in activity. It is important to remember that most abdominal pain relates to the gastrointestinal tract. The gastrointestinal tract has certain functions to perform. These functions are performed by virtue of certain activities in which it must engage. The function of the stomach is digestion, which is merely putting into solution the insoluble substances. It does that through its activities: secretion, motility, and tonicity. We are normally unaware of these activities. They go on constantly all day without our knowledge. We become aware of them only when the activity is intensified, delayed, altered, or exaggerated. For instance, we may have increased secretion or hypersecretion. Pyrosis is the symptom because it signifies an increased activity. Motility is another example. When it becomes altered, we become aware of it. The patient describes it as butterflies, or stomach movement. The third activity is tonicity. Increased tone results in the condition known as pylorospasm, and the symptom is the sensation that something is stuck.

So, a combination of these three activities produces postprandial pyrosis with exaggerated stomach activity and the feeling that there is something stuck. The patient calls the sum total indigestion or dyspepsia. Such a patient comes in complaining of periodic distress, and this identifies it as an alteration in the activity of his stomach. This alteration in the activity of the stomach may proceed to the point where it is actually associated with ulceration of the stomach, or it may occur because the patient has an ulcer. The symptomatology is identical. The only time we know for sure that an ulcer is present is when it bleeds, ruptures, or obstructs. Otherwise the symptoms can be entirely mimicked in the absence of an ulcer.

This same sort of increased activity can be initiated by other things than ulcer and this is important. You can even have a degree of pylorospasm with marked 24 hour gastric retention due to gallstones without there being any lesion whatever inside the stomach or duodenum. You may have the same sort of pylorospasm produced by mesenteric adenitis, acute appendicitis, or anything which leads to increased activity.

The patient presented today is a man who has abnormal activity of his stomach. Our attention is focussed on the fact that his pain is periodic. We must determine whether he has an ulcer or some other mechanism which has set off the same thing. Maybe it is in the part of the gastrointestinal tract beyond the stomach, perhaps in the small bowel or colon. That too has certain activities. The small bowel is concerned principally with other facets of digestion and the transmission of food stuffs along its course. Incidentally, the small bowel is one of the smartest organs of the body. It seldom gets itself into trouble. It is insulted more than any other organ in the body, and it is remarkably free from disease. It makes momentous decisions. It is the organ to decide whether iron goes in or out, whether calcium enters or is excreted, and how much water the body needs. It gets into trouble very seldom.

The activities of the colon — secretion, motility and tonicity — are the same as in the stomach, but the motility of the colon is of two types: (1) segmental contraction and (2) mass evacuation. You can see immediately that there are two types of distress or pain resulting from disturbance in colon activity. The thing that will cause pain more than anything else is any interference with the orderly activity of the colon resulting either from obstruction or gastrointestinal hurry. Pain associated with increased activity of the dilated bowel causes cramps, and the cramps will be noisy, with the result that the bowel tones will be angry, resentful. If there is obstruction present which cannot be overcome, the bowel becomes frustrated. The bowel gets tired and, following the groans and grunts and gurgles, there will be squeals, soon to be

followed by silence. The bowel gives forth sepulchral bowel sounds.

The last category to consider is the paroxysmal pain. By this we mean an abdominal pain which is part of a picture of a paroxysm. In paroxysmal pain there is a parade of symptoms simulating a seizure. What would these be? The paroxysmal pain that occurs in metabolic disease, for instance in diabetic acidosis where the patient comes into the hospital because of abdominal pain and not the symptoms of diabetes. This is a writhing pain. It is associated with other things, especially excessive sweating. Usually the absence of any abdominal wall defense mechanism is a clue. A paroxysm of pain is often associated with sickle-cell anemia. Here there is a pattern of illness which suggests the diagnosis. Besides the sicklemia, the patient has other signs of a crisis. A typical paroxysmal pain is seen in porphyria, a pain of spasm, writhing intestines with intense pain, a soft belly, high pitched bowel sounds. It is not unlike the pain associated with cerebrovascular accident producing the postcentral gyral syndrome. It is the type of pain associated with lead poisoning.

It would seem to me that this man's pain would fit into the periodic pain and that it was associated with increase in the activity of his stomach leading to failure of digestion.

Dr. Freeark: We followed a much more superficial thought process, I suspect, but we came up with more or less the same conclusion that this man had an ulcer or ulcer-like symptomatology prior to exploration which was not relieved by the management that was attempted. His long and rather extensive work-up finally terminated with his appearance in the operating room. The findings at the time of surgery were rather unimpressive for a patient who was felt to have a duodenal or gastric ulcer of very long duration. The only abnormality was minimal stippling of the duodenum. The rest of the exploration was most unimpressive, and it left us in a quandary as to whether there was an ulcer that we could not see. Whether further intervention was indicated in the interests of diagnosis raised the always difficult question of opening the intestinal tract for a more careful inspection. At this point maybe we should hear from Dr. Straus.

Dr. Francis H. Straus: Dr. Foley has covered the preoperative assessment of abdominal pain. In this particular instance we are faced with a man who, by Dr. Foley's description, had periodic pain associated with excessive gastric activity and, although no organic lesion was demonstrated preoperatively, it was reasonable to assume that he had an organic lesion of the stomach or upper duodenum, presumably an ulcer. Unfortunately, when his abdomen was opened no ulcer was demonstrated. This necessitates a systematic and meticulous surgical exploration of the stomach and duodenum.

In the patient who has come to surgical exploration for suspected gastroduodenal disease, you must exhaust every available means of excluding a pathologic condition before deciding he is free of ulcer. It is not uncommon to have gastric ulcers high on the lesser curvature or in the fundus of the stomach that are not palpable and give little evidence on the external surface of their presence. The ulcer low in the duodenum, which gives the atypical clinical syndrome to which Dr. Foley referred, is also at times impossible to detect without opening the duodenum.

Let us assume that meticulous surgical exploration has been carried out and little evidence of ulcer has been identified. It would appear from the protocol that the surgeons assumed the existence of a functional disturbance related to that caused by ulcer. The vagus nerves were sectioned to reduce the excessive gastric secretion of which this patient complained. The pyloric sphincter was cut so that abnormal retention of gastric contents could be avoided. The major causes of distress due to ulcer have been eliminated, but his complaints remain. In eight days he had recurrence of his difficulties and soon was again to experience his periodic distress.

This raises the question of what other condition can simulate ulcer disease. The next organ in continuity with the stomach that is affected by food would be the pancreas. Pancreatic secretion is stimulated by the arrival in the duodenum of gastric content, and pancreatic discomfort can be epigastric, just as in this patient. We are accustomed to thinking of pancreatic pain as occurring in crises such as acute pancreatitis, but interference with the pancreatic excretory mechanism can result in an increase in the tension within the duct when the stimulus of acid or

food reaches the duodenum. I am sure that the pancreas was explored and was found normal. Palpation of the pancreas is a notoriously unreliable guide to pathologic conditions. Sometimes we can obtain an additional lead to the presence of pain of this sort if the pancreas is stimulated by a secretin injection. This causes an immediate increase in pancreatic secretion. I have occasionally used the test in an attempt to show that the pain was connected to hypersecretion of pancreatic origin.

Since this man has been operated upon, he has continued to have periodic pain, usually three or four hours after meals. That is the type of pain we ordinarily associate with duodenal ulcer, but he has been looked at and no ulcer has been found. The causes of duodenal ulcer pain have been obviated by surgical intervention, but he still has pain. He still states that when he has pain it lasts only three or four minutes. That is not the pain ordinarily associated with pylorospasm or hypersecretion or increased acid or chemical distress or ulcer distress. It sounds like increased peristaltic pain, especially in the high small intestine. We should consider pain resulting from hypersecretion and functional disturbance in the high small intestine. Dr. Foley gave a good description of obstructive phenomena in the small intestine. Yet when these obstructive phenomena are on a functional or organic basis high in the small bowel, there is not enough small intestine to give the groans and grunts, and so they are not found. The distention you find in lower intestinal obstruction is often not visible and cannot be detected by percussion. Such a high partial obstruction must be considered here.

I might cite one instance in which a somewhat similar picture appeared in my own practice. That was a woman with definite pain associated with eating but coming on about an hour after meals, reaching a crescendo and then disappearing. She had one other objective finding, and that was persistent blood in the stools. She had no demonstrable ulcer on x-ray but the pain was so characteristic of ulcer that I opened her abdomen with this provisional diagnosis. Instead of an ulcer I found a sausage-shaped mass below the ligament of Treitz, it proved to be a retrograde intussusception of the small intestine up to the ligament. I pulled it down and could feel a long tumor of the upper jejunum. I let go of the end, and it slipped back up to the ligament, and I opened it up and removed a pedunculated carcinoma. The retrograde intussusception occurred because the upper end of the intraluminal mass was fixed, and the mechanism that projects the movable tumor within the lumen of the bowel downward pulled the bowel upward instead. I have seen this on two other occasions in patients with intestinal obstruction in whom a Miller-Abbott tube had been introduced and there was intussusception at the point of the balloon of the tube in addition to obstruction lower down.

So the case this morning might be either functional — and I mean neurogenic or psychogenic — hyperactivity of the very upper small intestine, or it might be an actual partially obstructive lesion in the upper jejunum or pancreas. If it is in the jejunum or involves the mucosa, there should be blood in the stool, and I take it the stool was negative for blood. Blood may be absent in a benign tumor, such as a lipoma. I have operated upon two such cases that caused obstruction by intussusception. There are other very rare tumors of the lumen of the small bowel which are high up, but they usually cause intermittent or persistent bleeding.

I am sure that in this case the biliary tract was examined and was normal, but some functional disturbances of the biliary tract must be considered. The lumen of the common duct may be fibrosed. That will cause biliary colic and may cause jaundice; yet this man's history does not suggest biliary tract disease in which pain usually is referred to the back. I think disturbance of the bile tract between the hilus and the liver and papilla of Vater can be ruled out by the character of the pain, its periodicity and its relationship with meals. That leaves us, in this instance, with the upper small intestine and the pancreas as the most likely cause of his trouble. I have twice in my life explored patients for unexplained upper abdominal pain associated with food taking. One of these was a retroperitoneal lymphosarcoma with nodes throughout the mesentery of the small intestine. Retroperitoneal tumors usually give the picture of steadily expanding pain, and this man hardly fits that category.

I would recommend, inasmuch as this man's pain persists, that he be re-reviewed from the

standpoint of possible interference with very high small bowel function, which means follow-through x-ray study. X-ray studies are notoriously undependable when it comes to demonstrating neoplasm in the small intestine. I would suggest that he have a secretin test to see if it reproduces his discomfort. With a normal alimentary tract, secretin injection is unproductive of symptoms, but if it is not normal it reproduces discomfort.

Dr. Freeark: Would you agree that in this age group with carcinoma or tumors of not too great consideration and with the absence of some objective sign such as persistent blood in the stool that surgical exploration should be embarked upon reluctantly?

Dr. Straus: I should think it is a procedure only of desperation. When it is done without objective evidence pointing to an organ system and with pain the only presenting phenomenon, the wise surgeon is reluctant to explore.

Dr. Freeark: Have we reached a desperate situation here? What about surgical intervention in this case?

Dr. Straus: Obviously it did little good, but I think the decision must be governed by the extent of disability of the patient. The risk in simple abdominal exploration is so slight that it is not too important. The morbidity and discomfort should be weighed against the patient's suffering. For lack of an adequte diagnosis in this patient, the reasonable decision to explore was a proper one, but it did not pay off in relief of his symptoms.

Dr. Freeark: Dr. Straus, you emphasized the subtle evidence of high, lesser curvature gastric ulcers and low duodenal ulcers. To what extent would you prolong exploration? Was it proper in this man to institute the surgical therapy given? Is this not what gave vagotomy a bad name — applying it to functional disease? Would you have opened this stomach or duodenum and taken a look inside?

Dr. Straus: I would not accept my external findings. He was subjected to exploration to find out the cause of his abdominal pain. Nothing was visible on inspection and palpation; and here, opening the stomach to inspect its lumen does not seriously increase the risk of the procedure. Opening the duodenum, if necessary, does not necessarily increase the risk and may be the only means for a definitive diagnosis. The duodenum was opened here, because you cannot do a pyloroplasty without it. If there had been serious question of a gastric lesion higher up, there is no reason why a gastrotomy could not be done to settle whether the ulcer is present. Unfortunately, the very upper portion of the fundus can be hard to see, even with the stomach open. I think the surgeon who found no pathologic condition and did the pyloroplasty and vagus section did not help too much but succeeded in ruling out further serious concern with ulcer disease. The man still has his disease, but it probably is not ulcer.

How much time would I spend on further exploration in this man if I had his abdomen open and did not find ulcer? I would spend all the time necessary. He is a young man, and spending the time is safer than a second laparotomy, and I would run that small intestine down from beginning to end and gently palpate the pancreas; and I would examine the retroperitoneal tissues as carefully as possible.

Dr. Freeark: Dr. Foley, you did not say anything in your very excellent discussion about emotional maladjustment as a cause of gastrointestinal complaints. Are you sure this man's difficulty is not functional?

Dr. Foley: One cannot neglect that area in a discussion of bellyache. Symptoms are due to a disturbance of activity. The mind and the emotions may readily precipitate such abnormal activity and lead to symptoms. Whether or not an ulcer develops may be significant. But let us ask this man a few questions. (Patient entered at this point.) He described his symptoms beautifully when I spoke with him briefly just before the conference. What kind of work do you do?

Patient: I'm a foreman.

Dr. Foley: That means you have folks working under you. How many?

Patient: Fifty-two.

Dr. Foley: Where do you work?

Patient: In a factory. We make drinking straws.

Dr. Foley: You mentioned that these employees come to you for help, and if they have troubles they come to you to beef about it. Is that right?

Patient: Yes.

Dr. Foley: You are the middle man, the whipping boy. Did you do this work before you had your present troubles?

Patient: Yes.

Dr. Foley: Does it keep you in a turmoil?

Patient: Yes, all the time.

Dr. Foley: Do you like your job?

Patient: Yes.

Dr. Foley: Does it give you a feeling of gratification at the end of the day to feel you have done a good job?

Patient: Yes.

Dr. Foley: Do you have someone over you?

Patient: Yes.

(Patient left.)

Dr. Foley: So the complaints come to him from both sides. This is an area which we could explore. Maybe this is an area in which further investigations would be productive. Sometimes we should call in a detective agent or a sleuth to find out about some mysterious villain that is troubling our patients. You know if you want to find out what is in a room there are several ways to accomplish this. First, you can peek in through the key hole. This is not the manly thing to do, but sometimes it is justified. Maybe there is a tiger in the room. At other times, if you want to see what is in the room you can get a periscope and look through the transom. On occasion, however, it is best to open the door and look inside. One way or another it is necessary to find out what was this man's trouble.

Was he ever bothered with an ulcer? I don't think he ever was. He had an ulcer syndrome, but that is not an ulcer. I think the answer to his problem would be to get him away from being the whipping boy or middle man. This is why he has increased secretion and increased tonicity and increased peristalsis. We recognize the fact that he is in a job where he may be subjected to pressure which produces these increased activities, so we cut the nerve to prevent it, but that does not answer the problem. We have to get at his primary problem and solve that so he can accept being a whipping boy without these disturbances. That would be my recommendation.

Dr. Straus: I agree, but I would still like. before you call in the detective, to rule out more carefully the very upper small intestine and the pancreas, not by surgical exploration but by simple function and x-ray exploration. This should be done before you get a detective or at the same time. It may not be fruitful and in most cases it is not. You do not often find organic pathologic conditions in these cases, so Dr. Foley and his key-holers are definitely in order.

Dr. Freeark: Dr. Foley, you did not have in mind in this key-hole idea such diagnostic procedures as gastroscopy or peritoneoscopy, did you?

Dr. Foley: I think the inference is obvious.

Dr. Manuel E. Lichtenstein, chairman, department of surgery, Cook County Hospital: This was one of the most enjoyable sessions we have had for a long time because of two men who have spent much time at the County and have dealt with these patients. They have seen disappointments on both sides of the fence, medical and surgical. I cannot add anything to their discussion except to emphasize one point. There has developed the habit of saying, "We'll get an upper GI" or "We'll get a lower GI x-ray study." I have in mind a hospitalized patient whose doctor ordered an upper GI study and found nothing. He ordered a lower GI, and nothing was found and the patient was discharged. He, however, continued to complain that he still had the pain he had before and no one could tell him he was "nuts." He knew he was not nuts because he didn't have the pain in the upper or lower GI. He finally went to an 80 year old doctor who sat down and talked to him and this doctor said, "Let us see; you had an upper and lower GI. I think I'll have an in-between GI," and she did; the x-ray picture showed stenosing ileitis. Within a month of the upper and lower GI, this man had developed progressive stenosis with edema that resulted in occlusion of the ileocolic branch of the superior mesenteric artery, and he required resection of the right colon and about 6 feet of the small intestine. It is remarkable that in such a short period of time he had so much trouble that neither the upper nor the lower GI demonstrated. So we should throw out this phrase. If you are going to investigate the gastrointestinal canal, investigate the whole thing.

There is one additional point for the surgical residents. For a long time in this hospital there has been a phrase commonly used: "Take a damn good look." Don't be like the surgeon who opens the belly through a tiny incision, puts his hand inside and looks up toward the ceil-

ing as though seeking Divine Guidance. Make a hole that is big enough and take a look inside. Dr. Foley mentioned the key hole and the periscope and looking through the transom. You don't have to do that. You can open the door and take a look. That is the manly thing to do.

This is really a serious subject. Here is a man who got medical and surgical treatment and is still complaining of the same trouble. He has not been benefited, and we are laughing at ourselves. There are other patients who are not always benefited by surgery — for instance, the patient who has gallstones. Many people have gallstones which give pain, but many have gallstones that are just like visitors or tourists: They are there but they do not participate. They do not make pain. There are many elderly patients who have gallstones and have had them for years with no symptoms. If the same patient develops symptoms and you take an x-ray that shows gallstones, it is not right to put two and two together and get four: to say the patient has gallstones and the pain is due to gallstones and he needs cholcystectomy. He may have distress in 12 areas in the abdominal cavity that give symptoms identical to those of gallstones. Just because we find stones does not mean that they are responsible for the complaints.

Too often we take out a gallbladder filled with many large stones. The patient shows them to the family and he shows them to all his friends; and then later when he sits down to eat he has the same darn pain. I know of a patient who had pain in the right upper quadrant near the midline. The abdomen was very tender, and x-ray showed gallstones. He had a cholecystectomy, and on the fourth postoperative day paraplegia developed because he had a spinal cord tumor. In the early phases he had the irritative phenomena of pain along the intercostal nerve. The finding of gallstones led to an operation that did not relieve him. The tumor was removed, and he got rid of the pain; but he had a long convalescence from the two operations.

I just want to emphasize this one thing: If you are going to investigate, then really investigate. Dr. Foley said to call in a sleuth. What is a doctor? He is a diagnostician. Just listen to what the patient has to say and ask the proper questions. Get laboratory work done that is of diagnostic significance, not just routine laboratory work but essential work. Dr. Straus has one of the largest collections of tumors of the stomach and duodenum. Any person who has worked in this field knows that they are most deceptive. You see films of a patient who within eight months has intestinal obstruction from carcinoma of the jejunum, and you wonder how it could have been missed eight months before. The problem of chronic abdominal pain is not an easy one.

Dr. Freeark: When we selected this subject, Dr. Baker said it would be very difficult to present and that the case was not a good one for discussion purposes. However, we decided that with Dr. Straus, Dr. Foley, and Dr. Lichtenstein we couldn't lose? Thank you all.

Points to remember

1. Abdominal pain is one of the most frequent and sometimes the most baffling of symptoms with which the doctor deals. Its diagnostic value is often overlooked in the maze of laboratory tests and x-ray studies that are usually undertaken to investigate it.

2. In eliciting the history of pain, Ryle's ten questions are extremely important:

1. Character or quality
2. Severity
3. Situation
4. Localization
5. Paths of reference
6. Duration
7. Frequency
8. Special times of occurrence and nature of onset
9. Aggravating factors
10. Relieving factors

3. Previous medical and surgical experiences are important in the assessment of abdominal pain.

(a) Pain resulting from inflammation may be inhibited by the use of corticosteroids. The silent perforation of the steroid ulcer is an all too familiar example.

(b) Previous bilateral splanchnicectomy for hypertension may abolish peritoneal pain or, if carried out on only one side, may cause a generalized process to appear localized to only one side.

(c) Drugs such as chlorpromazine as well as the opiates reduce pain sensitivity.

4. Pain from the alimentary tract may result from:

(a) Strong contraction of smooth muscle —

e.g., a wave of peristalsis in bowel obstruction or acute obstructive cholecystitis.

(b) Chemical or mechanical irritation of inflamed mucosa — e.g., duodenal ulcer. The importance of previous inflammation is emphasized to indicate the relative insensitivity of the normal mucosa to such stimuli. The normal gut can be cut, burned, or crushed without the perception of pain.

(c) Traction on the intestinal mesentery.

(d) Stretching the capsule of a viscus — e.g., hepatic congestion in heart failure.

(e) Irritation of intercostal or splanchnic nerves by direct extension of inflammation or neoplasm — e.g., pain of pancreatic carcinoma.

5. Interesting pain patterns elicited experimentally which have clinical implications are:

(a) Inflation of a balloon in the common duct or irrigation of a T-tube with saline under pressure gives epigastric pain radiating to the back.

(b) In health, distension of the gallbladder produces neither change in cardiac function nor angina. If the coronary arteries are diseased, changes occur.

(c) Balloon distension of the lower esophagus gives pain which is usually described as a feeling of distension or fullness — never constrictive. In the majority of subjects, it is fluctuating rather than continuous. It may radiate down the left arm, seldom down the right or both arms.

(d) Instillation of 200 cc. of 0.5% HCl into the stomach of most patients with gastric, duodenal, or anastomatic ulcer will reproduce the pain and is relieved by emesis, aspiration, or neutralization of this material. When the ulcer is clinically silent, however, no response to this material is noted.

(e) Visceral pain from any portion of the small intestine is perceived in the periumbilical area while that from any portion of the large intestine is felt in the hypogastrium. The primary visceral pain may be followed by a secondary somatic pain over the site of the lesion due to spread of inflammation to the abdominal wall.

6. While the cause for pain is being sought, efforts to relieve it are not only humane but provide diagnostic clues. An orderly progression of analgesic medications beginning with aspirin should be tried and their effectiveness recorded in the chart. The response to tranquilizers, barbiturates, and placebos may provide additional information. Lastly, the judicious use of nerve blocks or regional anesthesia may prove informative.

Milk sickness' impact on history

There was one disease that must have intrigued an intellectual, curious person like John Weever. That mysterious ailment was milk sickness. Many a pioneer in Mid-America had reason to say with Abraham Lincoln's cousin, Dennis Hanks, "We war preplext by a disease cald milk sick," for milk sickness was a savage, pitiless disease that was dreaded. It was also called staggers, tires, swamp sickness, and trembles. It afflicted man and beast alike. Between the salt lick and the village of Evansville, the ground was strewn with the bleached bones of cattle that perished from this illness. In 1858 it caused half the deaths in DuBois County, Ind. In Pigeon Creek, Ind., in the autumn of 1818, it killed Nancy Hanks Lincoln (Abraham Lincoln's mother) as well as his great aunt and uncle within a period of six weeks. In 1839 it killed 50 of the 500 people living in Danville, Ind. What would we think of a disease that struck down a comparable number of people in Evansville today —12,500 souls in one year? A nearby village, which was one of Evansville's early rivals, was abandoned because of milk sickness. The impact that this disease had on the early history of Indiana is simply incalculable. *W. D. Snively, Jr., M.D. Medical Practice A Century Ago. Arizona Med. Aug. 1960.*

The VIEW BOX

Franz Gampl, M.D., *Chicago*

This 76 year old white female was admitted to the hospital with a history of a weight loss of 25 pounds in the last five years, mild dysphagia, and occasional regurgitation of her food. She also complained of constipation.

The physical examination showed the typical findings of Parkinson's disease and was otherwise noncontributory.

X-ray of the chest was ordered as part of the routine evaluation of the patient.

What is your diagnosis: Mediastinitis
Carcinoma of the esophagus
Achalasia
Diverticulum

(*continued on page* 204)

From the radiology department, Cook County Hospital

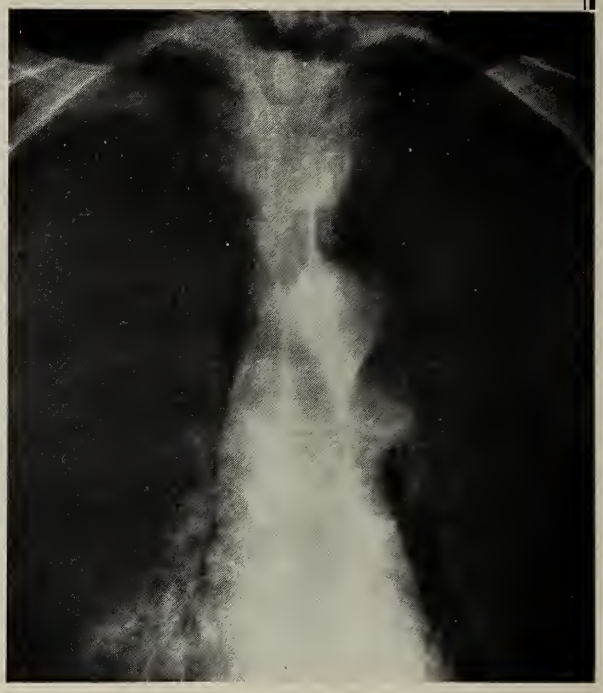


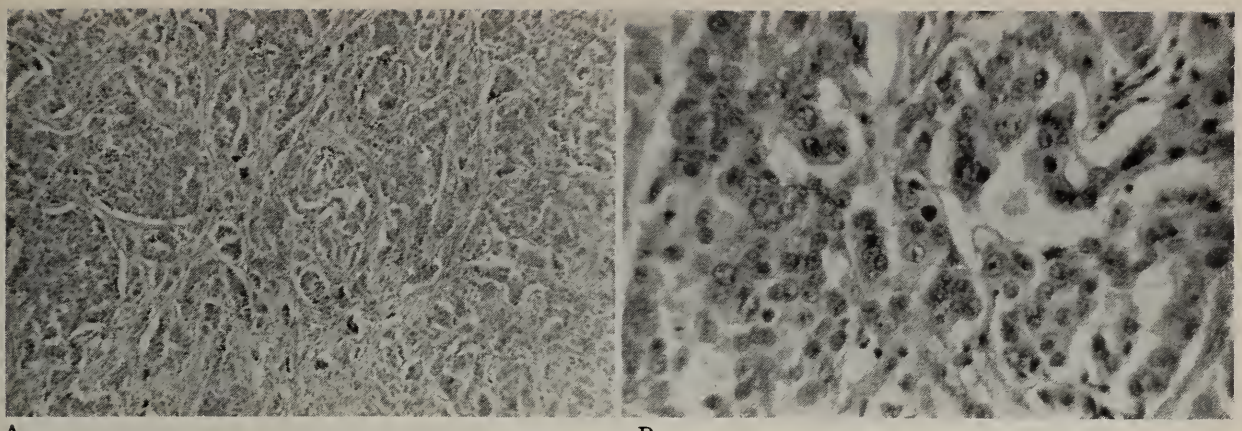
Figure 1. Routine chest roentgenogram.

Adventures in country living

I now have no doubt that a country cottage is the best antidote to a consultant's life in a large industrial city. Stepping over the threshold seems to induce relaxation.

It isn't like the Ritz; and indeed the farm worker viewed it as unfit for human habitation and says that he's happier in the modern bungalow which has been built for him. With this excuse we have eagerly seized the cottage, and put it into good shape, mainly with our own hands. It is timbered, black and white, and built about 1640, and the presence of electricity enables us to rough it with electric blankets and other comforts when necessary. So far only one thing has marred it. The mental tranquility of the Sunday has sometimes been replaced on the Monday morning, during Outpatients, by a humiliating looseness of the bowels.

I had thought of consulting a psychiatrist, as it seemed an obvious escape mechanism, symbolising an unconscious desire to rid myself of the humdrum of routine work. But serious consideration will now have to be given to an alternative diagnosis. I've just discovered that there is a dead horse in our water-supply. *In England Now, A Running Commentary by Peripatetic Correspondents. Lancet. Dec. 3, 1960.*



A.

B.

Figure 1. (A) Photomicrograph of infiltrating duct carcinoma of right breast removed in 1943. (B) High power view of the same tumor showing epithelial cells with large, round, hyperchromatic nuclei.

Primary Carcinoma in the Area of Radical Mastectomy Seventeen Years Later

M. S. Mazel, M.D., and R. Urban, M.D., *Chicago*

A review of the literature indicates that a new primary carcinoma of the breast is relatively rare in patients who have had a radical mastectomy. Most of the reports in the literature deal with late recurrences of the metastatic lesions. When they do occur, independent primary carcinomas are most frequently found in the gastrointestinal tract, rather than in the breast.

This is a report of a primary carcinoma occurring near the lower end of the scar in a patient who had had a radical breast resection. The original carcinoma, which proved to be an infiltrating duct carcinoma, was in the right breast. Seventeen years after the radical mastectomy, a primary carcinoma developed at the edge of the scar at about six o'clock and, when removed, was found to be a papillary adenocarcinoma.

History

A 40 year old white female was admitted to the Edgewater Hospital on June 30, 1943. Her chief complaint was pain in the right breast which began several days before her admission. She had noticed a lump in her breast seven months previously.

Examination revealed a movable tumor about the size of a lemon in the right upper quadrant of the breast. The glands in the right axilla were moderately enlarged and palpable. A radical mastectomy of the right breast was performed on July 2, 1943. All of the subcutaneous tissues, the pectoralis major and minor muscles, fascia, the subclavicular and axillary lymph nodes were removed (Fig. 1).

Diagnosis was infiltrating duct carcinoma of the right breast with metastases to the axillary lymph nodes (Fig. 2).

Grossly the tissues on section had pearly gray, cyst-like areas. In one area, these were honeycombed cysts up to 2.5 cm. in diameter. In addition, a few isolated glands were found that had been taken from the axillary area and subclavicular regions.

Microscopic examination revealed dense fibrous stroma sheets and strands of carcinoma cells infiltrating throughout. In places, these

From Edgewater Hospital, Chicago.

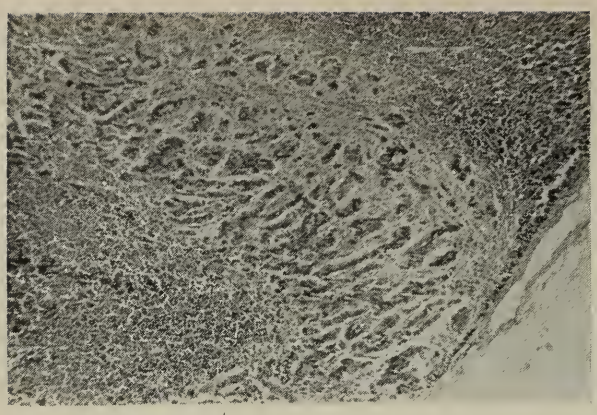


Figure 2. Photomicrograph showing metastatic carcinoma cells in axillary lymph node.

were arranged in the form of glands. Scattered abscesses were found throughout.

The patient made an uneventful recovery following surgery. She was given postoperative radiation treatment consisting of a 3,600 r tumor dose in the mid-axilla and substernal area within five weeks following surgery, as well as irradiation castration because she was still in the period of her menstrual cycle. This consisted of 1,200 r to the ovaries within eight days.

The patient was rechecked and the breast examined every six months following discharge from the hospital on July 9, 1943. A flat x-ray film was made of the chest once a year. She remained well and free of complaints until early November, 1959, when she noticed a small nodule just below the scar of the previous operation. The nodule (5 x 5 mm.) was freely movable.

She was admitted to the hospital on November 20. On the following day, a wide elliptical incision was made down to the ribs. The entire nodule was removed with skin and subcutaneous tissues.

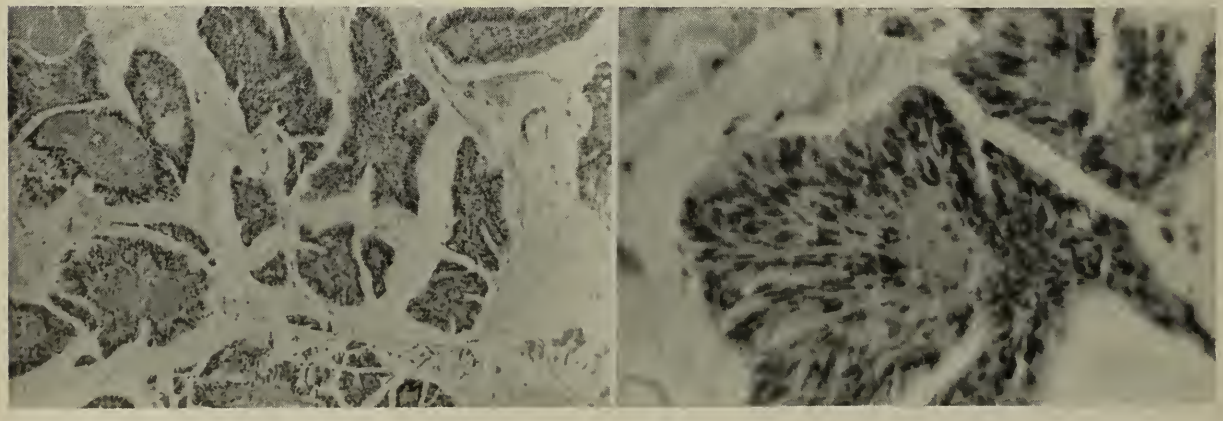
On section, this 5 mm. tumor mass was surrounded by a dense fibrous capsule. Serial sections revealed that the capsule was invaded by tumor tissue in three places. The tumor was papillary and lined with one to three layers of tall columnar cells with oblong, hyperchromatic nuclei situated in varying levels (Figs. 3A and B). The core of the papillary processes consisted of fibrous connective tissue containing blood vessels. The capsule of the tumor was surrounded by mature adipose tissues (Figs. 3C and 3D).

Diagnosis was papillary adenocarcinoma, right breast.

The patient was discharged from the hospital on December 2. Outpatient postoperative radiation treatment consisted of 2,400 r (air) to the right mid-chest wall within eight days.

Comment

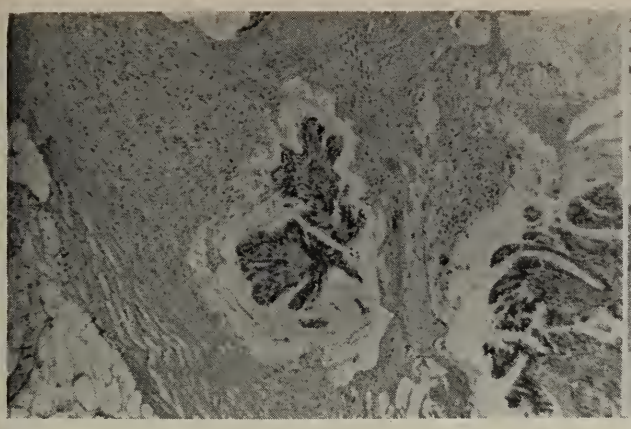
The question arises whether this lesion was a primary tumor or whether it presented a remnant from a breast carcinoma removed seventeen years previously. The histologic appearance of the lesion and the time interval involved makes the diagnosis of a metastatic tumor unlikely. It was felt that this tumor was a low grade papillary carcinoma arising from an aberrant duct of breast tissue. The definite capsular invasion supports the diagnosis of carcinoma.



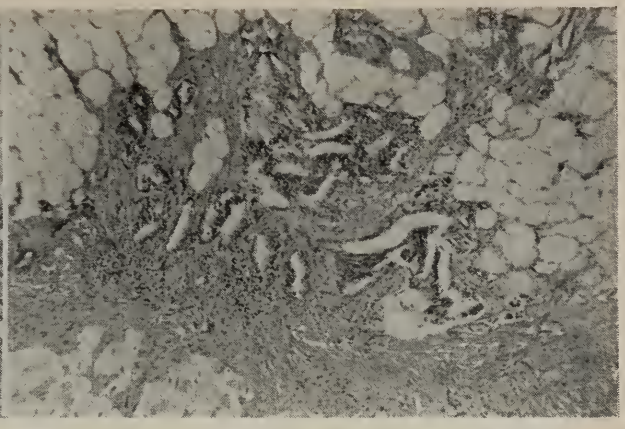
A.

B.

Figure 3. (A) Photomicrograph of small, papillary adenocarcinoma removed from right breast area 17 years after mastectomy. (B) High power view of the same tumor showing numerous large, oval and oblong hyperchromatic nuclei, situated at various levels in the epithelium of the papillary processes.



C.



D.

(C) Photomicrograph of the same tumor showing invasion of the fibrous capsule. (D) Photomicrograph of the same tumor invading the fibrous capsule and the pericapsular fat.

A review of the literature revealed a number of cases of multiple primary cancers. Dixon[1] reports a case of independent carcinoma of the colon occurring twenty-one years apart. In this case an adenocarcinoma was removed from the colon and twenty years later, two more primary tumors were removed from the same site and proved to be new independent primary growths of the colon.

Fried[2] reports on primary multiple cancers studied and divided into two categories: first, those which originated in organs of the same system, and second, those which arise in organs of different systems. Fried's report deals with 1,514 cases of visceral cancer but does not refer to any primary carcinoma in an area of previous mastectomy. Bowers[3] reports a case of simultaneous triple primary gastrointestinal carcinoma.

In a survey on multiple cancer, Mider[4] reviewed 3,996 patients who had primary malignant neoplasms of the stomach, uterus, breast, large intestines or hematopoietic systems, and found other primary cancers in 179 (4.5%).

In comparing the number of second cancers that followed or occurred simultaneously in the specific sites studied, Mider came to the conclusion that the number of second cancers following the first occurrence is greater than would be expected to occur by chance alone. In his studies, he found that second primary cancer occurs more frequently in the area of the breast or large intestines than in other organs. The relative frequency of multiple cancer in the breast among 941 patients with breast cancer was 6.3 per cent. according to the data presented by Mider. In the large intestine, the frequency of multiple cancers was 7.4 per cent; in the corpus uteri, 1.9 per cent.

Qualheim[5] studied the histologic nature of the presenting tumor of the breast in 156 cases and found that in 29 per cent of the grossly manifest carcinomas, the histologic pattern varied in different portions of the tumor. In this study, multiple cancers were found in 54 per cent of the specimens. The author suggested that breast cancer frequently arises simultaneously in many independent foci.

Summary

The authors reviewed the literature of primary recurrent carcinoma in the area of the breast following a radical mastectomy, and found that reports on recurrences of primary tumors are very rare. Most authors report recurrences of metastases several years after removal of the original tumor.

A case of a second primary carcinoma in the area of the right breast occurring seventeen years after a radical mastectomy is reported and discussed.

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MEDICINE IN THE OUT-OF-DOORS

THE CLARION call for the rebirth of physical fitness has been sounded by our national chief executives, past and present, and both are followers of the white pill. Not everyone has the inclination nor necessary agility for touch football, but anyone can swing a golf club, be he man or woman, hefty or frail. The equipment is modestly priced, serviceable for a number of summers, and where one plays can be adjusted

Join A



to his pocketbook and the company he keeps. This is one of the largest participation sports for post-teenagers.

Having been mesmerized by the cycloptic monster in the living room during the cold season, we are apt to take off for the greens in high gear with the first zephyrs of spring and the reassuring whistle from the cardinal atop the highest tree.

Our present mode of living is atuned to the quick start with little or no warm-up. Now home heating is only a matter of twisting a dial; our cars start pronto in severest weather, and we take off via automatic transmission, figuring our time of arrival at work in a matter of minutes. A third of our population has never known the slow, coaxing process of rekindling the kitchen stove or furnace, nor the laborious cranking of Lizzy and gingerly acceleration before it would drive with certainty. Small wonder that many cannot understand the necessity for slow, steady conditioning of mind and body for physical activity after a prolonged lay-off period. The discomforts following hasty, vigorous exercise only reinforce the rationalization in the minds of many that they are too old for that "kid stuff," and back they sink into the abyss of spectator sportsmen. To make that abominable situation worse, we are told that it is proper to partake of certain goodies as we recline in satiated comfort. Less calories are burned off, more are stuffed in, and cholesterol arises.

Though the suggestions for conditioning one's self for the golfing season are numerous — (it is not surprising to find hypnotism advocated to improve concentration and swing) — the most important decision is to choose a plan and work at it. Adjustments in any plan will become apparent the longer it is practiced. One such program used over the years by serious students of the game follows:

Foursome



JULIUS M. KOWALSKI, M.D.,
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I. *Pre-season conditioning*

Five minutes or more of exercises each morning of the week with emphasis on the following:

(1) Walk around the room first on the toes, then on the heels.

(2) Do 10 to 20 full knee bends.

(3) From an upright position, attempt to touch your toes with finger tips 5 to 10 times, coming up to a standing position after each attempt.

(4) Stand with feet spread apart slightly wider than shoulders' width. Bend trunk forward so the chest is parallel to the floor. Extend arms sideways at shoulder level and alternately touch toe of left shoe with fingers of right hand and toe of right shoe with fingers of left hand. Start slowly and increase cadence slightly through 15 to 20 such movements. Increasing the width of the stance enhances the benefit from this exercise.

(5) In standing position with arms extended to the sides at shoulder height, roll the shoulders forward in a circular motion, then backward in a circular motion. Repeat 10 times in each direction. When properly executed, the extended fingers should describe ever larger circles.

Excessive or violent exercising must be avoided. Slight strain and moderate fatigue developing gradually is the object. Pace each exercise to your build and physical ability. The longest journey begins with but a single step in the right direction.

II. *Pre-game suggestions*

Loosen up before the game.

(1) Repeat any or all of the conditioning exercises.

(2) Swing a cluster of clubs repeatedly after the fashion of a baseball player before he goes to bat.

(3) If the weather is hot or humid, don't forget the salt tablets.

III. *During-the-game suggestions*

On a very warm day, consider the following:

(1) Make use of the benches at each tee.

(2) Wear a ventilated hat or cap on sunny days; sun glasses are helpful too.

(3) The pulse rises imperceptibly while pulling a cart over a hilly course; so check it after every two or three holes. If it is 100F. or over, sit in the shade until it returns to normal.

(4) Drink small or only moderate quantities of water often rather than overload the system at one time. No alcoholic beverages during the game.

Golf is not without inherent hazards because of manifold exposures, and, bearing some of these in mind, one is prepared to prevent their occurrence or, in a measure, to fend them off.

When the cry "fore" is heard, don't look about to see if the warning was meant for you. Crouch from immediately to make yourself a smaller target, covering head and neck with your hands and arms. Unfortunately, a number of serious face and head injuries occur each season.

Every persevering golfer will eventually have his encounter with poison ivy. Learn to recognize it—first from illustrations, and then have it pointed out to you by the greenskeeper or someone who knows it by sight in its various forms as a shrub, trailing vine, or climber. "A thornless stalk with leaflets three, let it be, it's poison ivy." The rough is always the ivy zone even on the best of courses.

The sudden and unexpected assault by a stinging insect has ruined many an otherwise pleasant outing. A recent survey by the National Office of Vital Statistics discloses that more people die of insect stings than from poisonous snakes. Every patch of blooming clover or alfalfa is the domain of the bee, and a blundering intruder will soon learn of this. Wasp and hornet hives are suspended from branches or under eaves of buildings. Some species make their homes in the ground in a protected habitat usually found in the rough. Step with care; be ever watchful above and below, and move slowly so as not to arouse the insects if suddenly you find yourself in their midst.

When dark clouds begin to roll and winds are gusty, stop the game and get under safe cover. A sudden storm accompanied by severe lightning for one trapped on a large open plain is terror at its worst. Keep away from a lone tree or a small group of trees. If refuge is taken in a grove, keep away from the taller trees in that grove. Keep away from an isolated shed or shelter in an otherwise exposed area. Avoid fences and hilltops or other high places. Keep to low ground, and if caught on a large open expanse, lie flat on the ground with golf clubs and cart well away from you. It's better to be alive, though you be wet, muddy, and cold.

12 million yaws

Biostatistics for Africa as a whole show that, of its population of 155 million, 2.3 million are lepers, 20 million are afflicted with onchocerciasis, or river blindness; 12 million are suffering yaws, a disfiguring and mutilating disease, and 100 million are exposed to malaria. *Leslie W. Knott, M.D. and Henry N. Doyle. World Health and Industrial Medicine. J. Occupat. Med. January 1961.*

The View Box—diagnosis and discussion (*continued from page* 198)

A fluid level in the upper mediastinum can be seen in the first roentgenogram, more clearly on the enlargement (Fig. 2). Such fluid levels may occur in a variety of clinical conditions and may be pulmonary, mediastinal, or esophageal in origin. A barium examination revealed a large pulsion (Zenker's) diverticulum arising from the posterior wall of the pharyngoesophageal junction.

The esophagus was compressed from the right and posteriorly. Surgery was necessary to relieve acute obstructive symptoms which developed while the patient was in the hospital. The radiographic findings were confirmed.

Diverticula at the pharyngoesophageal junction may be subdivided into three groups according to their location:

1. Posterior diverticula
   (a) Zenker's pulsion diverticulum which develops at an area of muscular weakness between the oblique and transverse fibers of the inferior constrictor muscle. It is the most commonly encountered diverticulum in this area.
   (b) Rare forms occurring above (Killian) and below (Laimer) the Zenker's. These are also acquired.
   (c) Extremely rare congenital diverticula.
2. Lateral diverticula or pharyngoceles
   These are also rare and are explained by persisting remanents of the 3rd and 4th branchial clefts.
3. Anterior diverticula
   Extremely rare.

Zenker's or pulsion diverticula occur in the older age group with a peak incidence in the seventh decade. They first appear as horizontal outpouchings on the posterior wall of the pharynx. Later, with increasing size, they become directed vertically.

The most common complication is the accumulation of food particles and secretions within the diverticulum, favored by the absence of a muscular coat. This leads to inflammatory changes, pressure upon the esophagus, dysphagia, and inanition. Ulceration, mediastinitis, and carcinoma are the less frequently encountered complications.

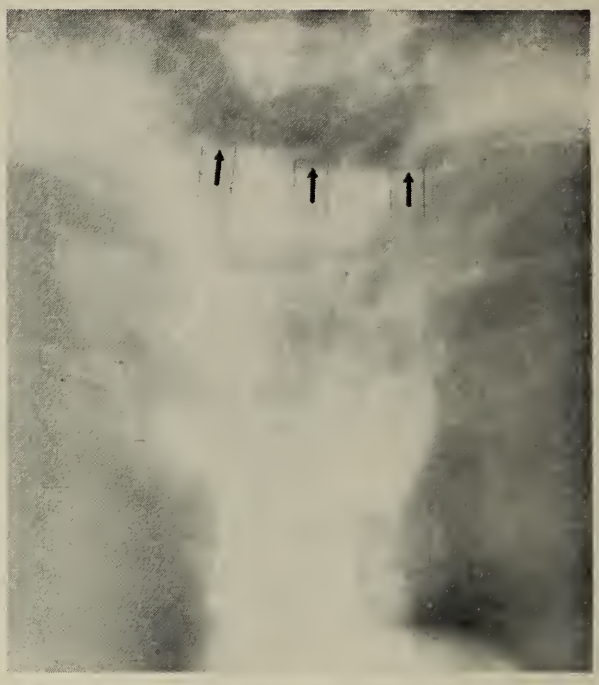


Figure 2. A cut-out from the plain chest roentgenogram showing more plainly the fluid level in the upper mediastinum.



Figure 3. Barium-filled esophageal diverticulum.

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Program Goals in Health Service For the Aging and Older Person

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Health departments and health officials have a responsibility for the health of all the people of a community. With more effective control of the diseases of childbirth, infancy, and youth, loss of life from these devastations has greatly decreased. Accordingly, the community now must strive for control of those diseases most common in older age groups: cardiovascular-renal diseases, cancer, diabetes mellitus, arthritis, rheumatism, gout, and the manifestations of the many changes associated with the climacteric.

Aging, however, is not necessarily synonymous with chronic illness or senescence. It is estimated that by 1970 there will be over one million citizens in Illinois over 65, the majority of whom will be healthy, strong, and active. In view of this, plans for longer human existence are indicated. The prevention or delay of the development of the degenerative diseases is the most important responsibility of medicine today in order that the potentialities of the elderly may be more widely developed and utilized.

"The ultimate hope, of course, is for prevention. There are two forms of preventive medicine: the community type represented by the typical public health approach, and the private type given in the offices of private practitioners of medicine."[1] The predominant role must be played by the private physicians.

Every individual should have a family physician and dentist to provide continuous guidance and supervision in accordance with accepted medical and dental standards and individual needs. Public health programs directed toward maintaining, improving and promoting the health of individuals should include a plan of education to bring these individuals into effective contact with the health and medical resources in the community. These resources should include the physician and dentist who normally serve the individual.

Preventive health services

Any health program for the aging and the aged should emphasize the development of personal preventive health services for adults. Aging is a biological and physiological process going on in each of us. Biological barriers to long life include tissue deterioration, which usually begins to manifest itself between the ages of 35 and 45 years. These are degeneration of the vascular system, the skeleton, and the nervous system. Suggestive experimental data indicates more effective control of these tissue breakdowns in the not-too-distant future. Health — physical and mental — implies more than disease prevention. It encompasses an optimum condition of dynamic well-being for each growing or aging individual. Deterioration must be kept to a minimum, and active measures including diet, weight control, exercise, work, rest, and recreation are essential. "Therefore, any program designed to meet the health needs of the aged should not be too narrowly limited to persons in any arbitrary age group. Such a program would not only limit the possibility of assistance to persons in need of help before arriving at such age but would necessarily limit efforts aimed at the prevention of disease and disability in the aged group."[2] The progressive development of a number of chronic diseases, or of the complications due to them, can be prevented by early detection and treatment. Greater attention to the promotion of positive health or a higher level of chronic wellness (as opposed to chronic illness) from infancy through adulthood beyond the years of maturity is essential.

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Presented at the Joint Conference—Cook County Committee for the White House Conference on Aging and The Illinois Gerontological Association. May 19, 1960.

This is the eighth in a series of articles sponsored by the Committee on Aging.

"A comprehensive health examination by a physician annually remains the ideal approach to early detection of chronic diseases. The closest approximation to this ideal has probably been achieved in pediatrics, which focuses more and more on health supervision of the child. No other branch of medicine is at present so well prepared to apply and develop the principles of preventive medicine and to care for the entire family's health. More and more young people are reaching maturity with some appreciation of what a physician can offer through health supervision and anticipatory guidance. The pediatrician has developed . . . a market for the health supervision at all ages."[3] There is no reason to assume that anticipatory guidance should not continue through life.

Although the annual comprehensive health examination is recommended by physicians generally, public health agencies, voluntary health associations, life insurance companies, and others, the extent of the periodic health examination is not good. Perhaps one of the major reasons for nonacceptance of this preventive health measure is that we have been a sickness-oriented rather than a health-oriented nation. Physicians generally are still not oriented toward nor sufficiently interested in health maintenance work. The care of the sick more than occupies their available time. Another factor in attaining the ideal of periodic health examinations is that of public response. Most people are not yet sufficiently motivated to seek a comprehensive annual health examination, in view of the cost involved. The average person can usually afford the fee for the first physician seen but in many instances finds it difficult to meet the costs of consulting physicians, diagnostic aids, hospitalization, surgery, and rehabilitation. Perhaps this lack of motivation may not be so unfortunate at present in view of the lack of availability of the service. Nevertheless, the ideal of an annual comprehensive health examination remains. It will someday be achieved for the population as a whole — when we have increased the number of physicians, changed the emphasis in their medical education from the treatment of disease to the maintenance of health including anticipatory guidance to live to 100 years or beyond, organized medical services so as to make them more efficient than at present, and developed public understanding of the value of the periodic health examination.

"The United States National Health Survey reports that in the 12 months from July, 1957 to June, 1958, acute respiratory illness caused 45 per cent of all bed-disability days, 36.5 per cent of work-loss days, and 67 per cent of school-loss days. Of 764 million days of bed disability caused by all chronic conditions in the United States in one year, 593 million were from acute respiratory disease. The work-loss days for the year were 219 million from respiratory disease and 226 million from circulatory, digestive, and arthritic disease, and impairments from injury or other origin combined. The average number of days lost by the usual working population from acute conditions was 5.98 and from all chronic conditions 6.52. These data represent the non-institutionalized population of the country and emphasize how infections and chronic disease conditions repeatedly interrupt healthy effective life. The so-called health statistics are commonly disease or death statistics. . . .

"The available measurements of health are few. We have no adequate body of measurements of health that are not based on the absence of a disorder. If we measured disease in terms of health rather than defining health in terms of disease, then our efforts could be directed toward preservation of the norm. Contemporary practice emphasizes deviations from the norm, and our current ability to detect and identify disorders depends largely on their severity; what we consider incipient is an already far-advanced biological imbalance."[4] Clinical attention and much public health effort centers on the hope of restoring function or maintaining it at a level that will permit a useful life. Unfortunately, with the chronic diseases, so-called therapeutic procedures do not commonly result in cures, for by the time the manifestations are recognized the defect is well advanced and not ordinarily reversible.

Care of the chronically ill

Progress in our ability to deal with these currently irreversible disorders, or chronic states, calls for research in the area of the common, annoying disorders of health, in which the preventive promise is high. The successful attack on the prevention and treatment of the communicable diseases of early life precludes the development of much tissue damage and foci of infection which, if permitted to occur, would be manifest later on as syphilitic or rheumatic hearts, nephri-

tis arthritis, or other chronic conditions. Careful obstetrical management is certain to prevent many future cervical carcinomas. The precautions taken by industry for the protection of its workers not only prevent many disabling injuries but, for some processes, also remove potential hazards that might lead to bronchitis, silicosis, occupational cancers, and other chronic diseases.

A most serious handicap to preventive medicine lies in the insidious nature of the development of the majority of chronic illnesses. Their onsets tend to be asymtomatic, and they often progress slowly with little or no pain or discomfort in the earlier states. This encourages the person afflicted, even when he suspects the condition, to delay seeking medical advice and care. One of the most fundamental handicaps, therefore, is the difficulty of getting individuals to protect themselves, to obtain periodic medical examination, and if necessary, early and adequate treatment.

The privilege of longevity carries with it the obligation of personal effort toward health maintenance. This, in consideration of the inherent frailties of human nature, is the seat of much of the problem. A number of psychological blocks must be counteracted. The individual must overcome a considerable amount of inertia and do something which is not of immediate or apparent benefit. Fear of a positive diagnosis serves as a deterrent for some, while others rebel at the thought of potential restrictions upon their personal habits and pleasures.

The only weapon available against these deterrents is increased and persistent educational measures. The ultimate goal should be the establishment of periodic medical examinations as part of the accepted cultural pattern as is immunization of children against many communicable diseases.

A total health plan for the aged must include care in the home, in the physician's office, in clinics, in nursing homes, and in hospitals. Since the total health team consists of the practicing physician, the health officer and the citizen, the more unified their common endeavor, the more effective the attack against the common threats to a long, useful life.

It will be the policy of the Illinois Department of Public Health to direct its efforts to the support of local programs in promoting continued guidance and supervision rather than isolated medical experiences. The impetus and leadership necessary to correlate and integrate the contributions and activities should be centered in a medically orientated official health agency — the local full-time health department. To attain maximum benefit from the vast store of knowledge pertaining to health of all persons in a community, curative and preventive medicine should be combined. Every physician's office should be a health station. Any plan for the aged must avoid encouraging unnecessary hospitalization or institutionalization in either private or public facilities. This is urged not only for reasons of economy, but also for the health, welfare, and happiness of the people involved. To this end the development of home care programs should come first.

The Illinois Department of Public Health is actively encouraging and assisting local, full-time health departments in the development of adequate home care, family-centered public health nursing programs. The objectives of such a program are to make it possible for older persons and persons with long term illnesses or chronic diseases to remain in their own homes rather than be put into nursing homes simply because they require occasional nursing care. The active follow-up of post-hospitalized patients represents a most important and expanding phase of the chronic disease program. The chronically ill and aged patient is far happier and healthier in his own home with familiar surroundings and proximity of those he loves. It has been estimated that about 70 per cent of such patients could be cared for satisfactorily in their own homes if adequate auxiliary services were available, and if the other members of the family were prompted and enabled to understand what is needed for the elderly patient in the home. It is here that the public health nurse can make a truly significant contribution to the program for the care of the chronically ill and aged.

Such a program should be supplemented by other ancillary home services such as homemaker services, home nursing training, and rehabilitation, including rehabilitation in the mental hygiene sense, and physiotherapy.

There is no need to postpone service until a full team has been recruited. By effective use of personnel in local health departments, state health departments, and voluntary health agencies, some of the gaps in service may be closed. Consideration should be given to training intelli-

gent local residents to serve in those positions where registered personnel cannot be hired. Self help and neighborly help is the major weapon in meeting the challenge of soeial neeessities. The deeline of family integrity has resulted in disrespect and indifference towards the health, happiness, and welfare of aging parents. Provision for the comfort and security of aged people should be a matter of pride for the family and for the eommunity.

Society's attitude toward older eitizens is in drastic need of a thorough house-cleaning. As Dr. Edward L. Bortz, Philadelphia, stated recently,[5] "There are a number of firmly entrenehed customs followed by business, industry, labor, the professions, and also by certain departments of government whieh militate against healthy aging. To begin, there is the unfounded point of view that age and deerepitude are synonymous. Ultimately, all living tissues suecumb to the inevitable, nevertheless much of what is stigmatized as the evidenee of age, is the result of poor hygiene in a broad sense. Retirement at sixty-five is a praetice that should be up for retirement itself. The loss of a job when a man has often reached his finest hour may shorten a man's life. For many it is a humiliating shock.

"Of eourse retirement means many things, aceording to the person and his desires and economic support. Too many of our older citizens aeeept defeat because the community emphasizes the faet 'You are an old man.' We are now facing a new frontier which promises a longer life, a richer life for our aging citizens. More frequently, it will be possible to reach the round century in reasonably good health. Publie Health reports state over twenty thousand American citizens have now reaehed the century milestone.

"To make the most of the added years an edueational philosophy should be evolved that will encourage reeognition of the potentials of mature existence. A blueprint for living one hundred years in good health and reasonably happy, might be drawn up. This will have its impact on all of the major areas of community life, business, industry, and the professions."

"Science knows enough today, there is sufficient, useful information to greatly diminish the nuisance disorders and much of the excessive wear and tear. Individuals differ. Excesses of all kinds with aceumulated wearincss and eumulative exhaustion set the stage for the vascular catastrophies and the neurogenic disorders whieh exact such a fearful toll. There is convincing evidence that much of the ordinary siekness of today ean be avoided. Indeed, the life span of experimental animals ean be practieally doubled by the use of an adequate diet restricted in calories, generous exereise and adequate rest periods.

"The years from sixty to ninety for many individuals represent the most enjoyable period of human living. For more people to gain the enduring satisfaetions implied in the phrase 'life, liberty, and the pursuit of happiness' a clearer appreciation of healthy practiees of living must appear. Experimental medicine is just now about at this point. It is most interesting to explore performanee potentials and motivation in older age groups."

It is estimated that 30,000 Americans past 65 are at home with some ehronic disability and may need some type of institutional care. When the medical problem eannot be handled adequately without eare in nursing homes or hospitals, then and then only should institutionalization be considered. The State Legislature in 1945 authorized the Illinois Department of Public Health[6] to license nursing homes in an effort to assure the maintenance of proper standards of eare and safety. A revision of this legislation in 1957 designated three types of institutions to be licensed — namely, nursing homes, sheltered care homes, and homes for the aged. Licensing, however, is only a part of this department's program for improving the eare of the aged. Special consultants in the area of nursing, nutrition, business management, health education, dental health, and nursing aid training are available.

The Illinois Department of Public Health, through its special consultants and its programs of chronie disease control, dental health, nutrition, tuberculosis control, and hospital and nursing home licensure and inspeetion, is working to prevent chronie medieal conditions and to bring about adequate carc facilities for the aged at thc community level.

Thc majority of old people aehicve a smooth and harmonious adaptation to the deeline in their physical and intelleetual prowess, and whilc awareness of declining faculties inevitably causes some emotional stress, it is rarely by itself the eausc of serious maladjustment. "An educational awareness," states Dr. Bortz, "nation-wide in scope, stimulated by progressive thinking and

planning on the part of physicians of all groups, the general practitioners, the Public Health physicians and those educators manning the facilities of our medical schools, would greatly reduce the indifference now widely extant concerning the exciting possibility of living a long and vigorous additional number of years. Defeatism must be eliminated and a strong hopeful outlook should be taking its place.

"Planning for the second career would move the date of retirement from sixty-five to eighty-five or ninety. In the later decades, from eighty on, with a diminished physical vitality, there is still a chance for continued intellectual growth and social participation. Indeed, there is less need for the heavy muscles, there is more need for agility of the mind. These intangibles are very real. They do not, however, lend themselves to the practices of precise measurements which are the accepted baseline for biological experimentation. Nevertheless, they are equally real.

"We are facing a new kind of society which is unfolding. The direction which this society takes will depend upon the goals it holds most worthy. In gaining added years, man is now face to face with the basic purposes of his own existence. Are the added years to be sterile visited by weakness, depression and deterioration, or are they to be characterized by the flowering of the major powers inherent in each citizen?" Security and longer life can be miserable acquisitions, if they mean only the continuation of unhealthy states.

While the control of chronic diseases still appears difficult, the situation is probably no different from that presented by communicable diseases 50 years ago. That problem is under constant and relatively effective attacks. In the light of recent trends, we may well look forward to similar results in the field of chronic diseases with the ever increasing knowledge provided by persistent research and the cooperation of the medical, public health, and social professions.

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Changing concept of aging

The very concept of aging has changed over the years. Today more than ever before, physiological aging in the human tends to lag behind chronological aging. Better medical care and health generally, safer childbirth, elimination of the communicable diseases as major causes of death—all have contributed to this result. It seems reasonable to expect such progress to continue—and to hope that, before the century ends, the frontiers of aging will have advanced another 10 to 15 years. *Increased Life Expectancy in the U.S. Health Information Foundation. December, 1960.*

Radiography side effects

Nausea and vomiting is comparable to that seen with routine intravenous urography. Flushing is present in almost all cases but passes quickly and is not a significant factor. Thrombosis at the injection site has been noted but not to the extent described by many authors. Extravasation has been infrequent but successfully treated by hyaluronidase (one case of minimal necrosis). Phlebitis has been rare, with only one case of minor phlebitis that responded rapidly to local measures. *Walter S. Keyting. M.D., et al. Nephrotomography and Intravenous Aortography. Rocky Mountain M. J. December 1960.*

EDITORIALS

Bill to protect the Good Samaritan

The following bill, sponsored by Paul G. Ceaser, representative to the General Assembly from the 3rd district, was filed in the Illinois State Legislature February 7:

"For an Act in relation to liability of physicians and surgeons for malpractice.

"Be it enacted by the People of the State of Illinois, represented in the General Assembly:

"Any physician or surgeon licensed to practice medicine in the State of Illinois who renders aid until regular, professional medical treatment is available to any person whose life or bodily health is imperiled by injury or sudden illness shall not be liable for malpractice in an action to recover for injuries sustained by reason of such aid, provided the physician or surgeon does not accept or receive anything of value or a promise thereof as compensation or consideration for aid."

Representative Ceaser needs your support in getting this bill through the Legislature.

Fibrocystic disease of the pancreas

Fibrocystic disease of the pancreas, or mucoviscidosis, resulting from pancreatic exocrine insufficiency is a congenital disease inherited as a Mendelian recessive.

There are five or six fairly well defined symptom complexes classified as celiac disturbances, but pancreatic involvement as a causative factor is evident in only two of these syndromes—fibrocystic disease of the pancreas and congenital obstruction of the ducts of Wirsung and Santorini. Mucoviscidosis, however, is the only celiac syndrome that has a widespread change of the mucus-secreting glands of the entire body combined with severe pulmonary disease.

Obstruction by inspissated secretions in the pancreatic acini and ducts causes dilitation followed by atrophy and fibrosis. Distention of acini and ducts of the salivary glands, mucus glands of the esophagus, duodenum, jejunum, and gallbladder are frequently encountered. Sweat, saliva, and tears have high concentration of chloride and sodium. Emphysema and atelectasis are early lung findings secondary to partial or complete obstruction of the bronchial tree by thick tenacious mucoid secretions. Bronchi and bronchioles gradually become dilated followed eventually by pulmonary fibrosis and interstitial pneumonia. The complete answer to this varied pathology is not known but is presumed to be a genetic defect that is basic in the production of an abnormal mucoprotein that dissolves poorly in water and becomes inspissated readily.

It is estimated that the incidence of cystic fibrosis of the pancreas is between 1:1,000 to 1:10,000. It rarely occurs in Negroes. The earliest recognizable evidence of this disturbance is meconium ileus in the newborn. A family history of previously afflicted children plus the symptoms of bowel obstruction lead one to the presumptive diagnosis. Laparotomy is necessary proof.

Many infants appear normal at birth but fail to thrive in spite of prodigious appetite. The stools are larger, frequent, and greasy. The combination of excellent appetite and failure to gain although intake is more than adequate should suggest fibrocystic disease. The pulmonary symptoms usually associated at some time in the course of the disease may at times precede the digestive disturbance. Unexplained recurrent, persistent upper respiratory infections and frequent, diffuse lower respiratory infections in early infancy are suggestive evidence.

The diagnosis is based on finding deficient pancreatic enzymes in the duodenal drainage and stools, a high concentration of chorides in the infant's sweat, and increased excretion of fat in the stools. Roentgenograms of the chest

are suggestive when pulmonary symptoms begin and more diagnostic as the lung pathology progresses.

Management is directed toward adequate diet with water miscible vitamin supplements and control of the respiratory infections. Some prefer restricting the fat intake; others offer full diets. Pancreatin—Panteric® granules are prescribed by many; others restrict their use because they seem to suppress the appetite. Antibiotics used therapeutically and prophylactically have increased the life expectancy and should be used extensively until a more specific treatment is found for this baffling disease.

L. Martin Hardy, M.D.

How the aged pay

It is refreshing to see a serious study made of the facts relating to the status of the aged with respect to ability to pay for their medical service. To us, such a study made by the Vermont State Medical Society's Committee on Aging, and reported last year in the *A.M.A. News* is highly illuminating.

The reason for the study was twofold: (1) Vermont has a higher percentage of its population over age sixty-five than any other state, and (2) with all the interest being shown in the subject of health care for the aged, the Vermont Society thought a survey of the way older people pay their bills might well be in order.

The study was thorough, well planned, and well executed. It should be of great interest to all who are sincerely interested in health care of the aged.

In reporting its findings, the Vermont committee said it made "no attempt to draw any 'earth shaking' conclusions." While different groups may interpret the findings of this study in different ways, the facts should speak for themselves.

The study covered 5,172 persons ranging from sixty-five to one hundred and six years of age. The median was seventy-four. Two women to every one man sought physician care in this age group.

The survey was made during January, 1960, with 188 private practitioners cooperating.

Here are some of the findings.

A total of 80.7 per cent planned to pay the physician's fee through Blue Shield, private insurance, from savings, or with current income.

The patients' families planned to assume the responsibility in 12 per cent of the cases. The responsibility fell to the city or town in only 5 per cent of the cases.

Physicians subsidized in full 2.3 per cent of the patient care reported, and gave "reduced charges" to 12 per cent. (The study did not attempt to cover the "free clinics" in the large hospitals around the state.)

It was found that 66 per cent lived with spouse or relatives; 20 per cent lived alone.

Twenty per cent of the group studied were still working; 70 per cent were retired.

Fifty per cent were on social security (the national figure is 60.2 per cent); 16 per cent were on Old Age Assistance, and 13 per cent had other retirement plans.

Blue Shield, which in Vermont can be purchased at any time regardless of age or physical condition, is helping to meet the costs of medical care by covering 40 per cent of those surveyed. Another 12 per cent have private health insurance, making a total of 52 per cent with some type of prepaid plan.

"Perhaps the 5 per cent of those who said the the city or town or state would pay the bill seems low to those outside Vermont," the committee said in its report. "But Vermont has no state-wide plan for the payment of medical bills for their recipients of public assistance. Vermont says this is a town responsibility."

The committee was impressed with the 32 per cent of house calls. "Who said doctors don't make home visits any more," the committee asked. "Even in January in Vermont."

All of this makes sense to us. The picture presented is that of a dedicated segment of the medical profession serving a self-respecting population. We commend this study and recommend it to our readers. *Editorial Comment. New York State J. of Med. Jan.* 16, 1961.

He that cannot forgive others, breaks the bridge over which he must pass himself: for every man has need to be forgiven.—*Lord Herbert*

AT THE EDITOR'S DESK



New Antigen for Diagnosing Trichinosis

Hyland Laboratories (a subsidiary of Baxter Laboratories) has a rapid new slide test antigen for use as an aid in the diagnosis of trichinosis. This Latex Trichina Reagent will compete with existing methods of diagnosing trichinosis, including complement-fixation, flocculation, and intradermal tests, all using an antigen prepared from the larve.

On the other hand, the advantage of the reagent is an adjustment in sensitivity, which enables it to react to the high titers found in active infection, not the low titers encountered in dormant sensitization.

Tuning in Chest Sounds

Calhear Instruments has acquired the national sales and distribution rights of the new model Primoscope ES-331. This electronic stethoscope amplifies over 100 times better than the standard acoustical stethoscope. In addition, it allows the user to tune for the exact tone he is interested in hearing.

It also contains an auxiliary audio output that allows connection of an additional headset, external sound system, or a recording instrument.

Faulty Tonometer

The February News Bulletin of the National Medical Foundation for Eye Care had an interesting editorial on scleral tonometry. This instrument has been used by optometrists to measure intraocular pressure. It is interesting to that profession because it can be used without a local anesthetic, which is not legally available to optometrists.

The editorial cited evidence that the Wolfe sclera tonometer was unreliable and failed in one study to detect elevated pressure in 82 per cent of 70 eyes with known glaucoma.

Oral Polio Vaccine Report

Pfizer made a recent progress report on their oral polio vaccine program. It is now being made at their Sandwich, England plant. Certain Pfizer scientists from the United States are assigned temporarily to this plant, which has facilities for production, laboratory work, safety tests, and animal holding.

Leukemic Enzyme

The American Cancer Society News Service had a recent release from the University of Washington, where members of the department of biochemistry and medicine found a substance that exists in leukemic white cells, but is not detected in normal cells. It is an enzyme called DR, or dihydrofolic reductase.

It may hold the secret to the dramatic help given some leukemic patients by anti-vitamins.

Fire-proof Mattress

The public may now smoke in bed. A new, patented mattress was announced recently that is flame- and mildew-resistant, water repellent, allergy-free, and never needs turning.

It is unconditionally guaranteed for 20 years and is marketed mainly for hotels, motels, and institutions. According to a release from the Prescription Bedding Company, the mattress was designed with medical counsel to support the spine in a natural position.

FDA Upsets "Chemical Smorgasbord"

The Food and Drug Administration has moved to stop the sale of Atlantic Ocean water for $3.75 per gallon. It had been recommended by an Ohio promoter as a "fountain of youth," as well as a cure for arthritis, cancer, diabetes, multiple sclerosis, Parkinson's disease and leukemia. Ac-

cording to the report, the promoter was using "reprints of syndicated newspaper articles written by Dr. George W. Crane" entitled "Chemical Smorgasbord vs. Cancer," "Worry Clinic," and "Oh, Dr. Crane."

The "Chemical Smorgasbord" reprints promised that " by taking a little sea water per day we can thus offer our bodily glands a 'chemical smorgasbord'. Figuratively, therefore," the article continued, "the pancreas, liver and spleen, bone marrow, thyroid, adrenals and other organs can march around this chemical smorgasbord helping themselves to whatever they require to produce the manufactured secretions that guard our health."

The FDA also reported that the last of a ring of rotten egg dealers were sentenced this month in Nashville, Tennessee.

To Aid Medical Research

The National Society for Medical Research has stepped up their program to make the donation of bodies for medical use more common throughout the United States. The society will present a wallet card to donors, and the editors of Reader's Digest are said to be working on a NSMR article for publication in a few months. The family of one who has donated his body to science may realize a saving in burial expenses.

Russian anatomists are having difficulty obtaining bodies for dissection. During a recent trip to Russia, Dr. Morris Fishbein was curious enough to ask why so many students were forced to work on the same body. The answer: The Russian people have reached a high level of prosperity and want a decent burial.

Statistical Corner

According to the Metropolitan Information Service, more than half of all the deaths in the United States now occur in hospitals.

Statisticians could make capital of this point, depending on how they feel about the medical profession and hospitals. To us it reflects a wider use of hospital facilities for the diagnosis and treatment of serious illness. It could be used to prove many an oldtimer's point of view: "Hospitals are a place to go to die."

Advice For Doctors With Dogs

The Pitman-Moore Company announced a breakthrough in the long search for an effective method of eliminating fleas, ticks, and lice from dogs. It is an oral pesticide, Ectoral, an organic phosphorus product or preparation.

Over-rated Urine

The Institute of Protective Analysis is a Blue Island concern under the directorship of M. C. Barlow. Its slogan: "The Lifesaving — Life Lengthening — Service." We received one of their advertising brochures and found that it was a urinalysis-by-mail organization. It was a touching brochure. For example:

"Every man owes his loved ones and his business the health protection of this service, and Every Woman owes herself, her husband, and her loved ones the same health protection. The special man-and-wife rate gives a wife this service for an additional charge of only $10.00."

Pollution Diminishes Fish Population

The U.S. Public Health Service informs us that first reports from 31 States indicate that agricultural pesticides and industrial wastes caused 70 per cent of the 185 pollution-caused fish-kills. A survey was made along more than 600 miles of streams and 5,000 acres of lakes during a nationwide Federal-State cooperative study from June to October, 1960.

This first nationwide study of stream fish-kills showed that agricultural poisons accounted for 73 out of the total 185 state reports. Industrial wastes were listed as the cause in 57, domestic sewage was listed 15 times (8%), while other causes — pipeline breaks, shipping pollution, etc. — numbered 17 fish-kills, and unknown causes 28. The average is 6,100 fish per kill by pollution.

We ought not to treat living creatures like shoes or household belongings, which when worn with use we throw away.—*Plutarch*

ANNOUNCEMENTS and NEWS

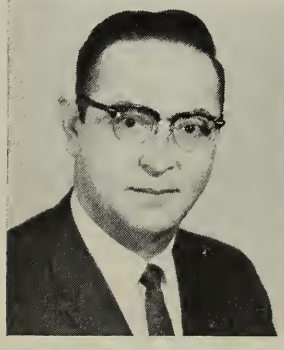
News and Announcements are curtailed this month to make room for annual meeting announcements.

TB Institute meeting changed

The Tuberculosis Institute of Chicago and Cook County has cancelled its Annual Spring Conference on Tuberculosis in March and changed the date of the meeting to October 11-14 to combine with the annual meeting of the Mississippi Valley Conference on Tuberculosis in the Hotel Sherman, Chicago. The preliminary program will be available early this summer.

Livingston joins Society staff

Mr. Walter R. Livingston will join the staff of the Illinois State Medical Society March 13 as assistant director of medical services and economic research. He comes to the society after serving nearly two years as research associate in the economic research department of the American Medical Association. Immediately prior to joining the AMA, Mr. Livingston was employed as an economist for the Roy Wenzlick Research Corporation, a St. Louis firm primarily dealing in real estate research. Before that he was on the personal staff of ex-President Herbert Hoover doing economic research and assisting the ex-President in the preparation of manuscripts, major speeches, and press releases.



Walter R. Livingston

A native of California, Mr. Livingston was graduated from Claremont Men's College with a B.A. degree in economics and business administration. He received a scholarship from the University of Chicago in 1955-56 for a year of graduate work. He continued his graduate studies at New York University's Graduate School of Business Administration while serving on Herbert Hoover's staff. He is now preparing for preliminary exams for his Ph.D. degree.

In 1958 Mr. Livingston was awarded a William Volker Fellowship to the Institute on Freedom and Competitive Enterprise—a two week seminar held in California. He is co-author of a recent article published in the Journal of the American Medical Association entitled "Medical Care Costs in an Extended Inflation."

GP's annual Scientific Assembly

The American Academy of General Practice will hold its Annual Scientific Assembly April 17 to 20 in Miami Beach. A panel discussion on "Economics of Medicine—Today and Tomorrow" will feature Walter Reuther, president of the United Auto Workers Union; Dr. E. Vincent Askey, president of the AMA; and other national figures. Dr. John S. DeTar, a former president of the academy, will moderate. There will also be 25 scientific lectures and medical panels and more than 400 scientific and technical exhibits.

Goiter Association meeting

The American Goiter Association, Inc., will hold its annual meting at the Warwick Hotel in Philadelphia May 4-6. A total of 35 papers will be presented.

Anesthesiologists annual meeting

The Illinois Society of Anesthesiologists will hold its annual meeting Sunday, May 14 at the

Palmer House. For further information write Dr. Richard E. Lyons, 424 Barton Place, Evanston.

Nurses and administrators conference

A Conference of Nurses and Administrators will be held May 2, 9:30 a.m. to noon during the annual Tri-State Hospital Assembly in the Palmer House, Chicago. The Assembly runs from May 1-3. The Conference is one of 36 Assembly sections discussing all facets of hospital service. About 400 nurses, physicians, and hospital administrators from the 4-state area of Illinois, Indiana, Wisconsin and Michigan are expected to attend the conference.

Surgical Society meeting

The Illinois Surgical Society will hold its annual clinical and scientific meeting Monday, May 15, with Surgical Clinics at Cook County Hospital and a Scientific Meeting the same night at 8 o'clock at the University Club, Chicago. Dr. George Crile, Cleveland Clinic, will be the dinner speaker -- his subject, "Results of Simplified Treatment for Carcinoma of the Breast." Physicians are invited to attend.

Fifty Year Club fathers and sons

Photographs of Fifty Year Club fathers and their physician sons will be taken 10 minutes before the luncheon on May 16 just inside the Assembly Room, where the luncheon is being held. It is hoped that a good number of these fathers and sons can be present.

Clinical Conference well attended

The Chicago Medical Society had a successful Clinical Conference the week of February 28. The meetings were well attended, and many of the speakers were renowned in their fields.

A breakdown of the 6,117 persons registered shows attendance as follows: Chicago physicians, 2,510; out-of-town physicians, 697; allied professions, 725; medical students, 262; scientific exhibitors, 85; technical exhibitors, 763; The Woman's Auxiliary, 306; guests, 759.

About 400 attended the banquet, which was followed by a program and dancing.

The Saturday afternoon program was limited to a talk by Mr. Boisfeuillet Jones, special assistant for health and medical affairs to the Secretary of Health, Education and Welfare, Washington, D.C. This was the first official address given by Mr. Jones, in which he outlined current health needs and the Administration's program. He spoke to a full house.

Aerospace annual meeting

The Aerospace Medical Association has planned its annual meeting for April 24-27 at the Palmer House, Chicago. Leading scientists in the field of aviation and aerospace medicine will present more than 180 research and clinical reports. Subjects to be discussed include aerospace pathology, otology, radiobiology, opthalmology, thermal stress, linear acceleration, oxygen equipment, protection, and general problems.

Obstetricians and Gynecologists meeting

The American College of Obstetricians and Gynecologists will hold its Tenth Anniversary Clinical Meeting April 24 to 28 at the Americiana Hotel, Bal Harbour, Fla. Before the general session, a program of five postgraduate courses will be offered from April 21 to 23 on genetics, statistics, radiation physics, parenteral nutrition, and steroid metabolism. Each will be led by an authority in that field.

Dr. Brieland heads Children's Services. Dr. Donald Brieland, psychologist of Barrington, became head of Children's Services in the Illinois Department of Public Welfare March 1. He is in charge of the preventive, educational, and residential programs of the department. Dr. Brieland had been executive director of the Elizabeth McCormick Memorial Fund of Chicago since 1954 and a member of the psychology department of Northwestern University. The department will continue its partnership with private agencies in the care and treatment of children, and efforts will be made to improve coordination, reduce duplication, and provide for essential children's services not now available.

Davis Lecture. The annual D. J. Davis Memorial Lecture on Medical History will be given

at 1:00 p.m., Wednesday, May 17, in Room 221 of the Dental-Medical-Pharmacy building of the University of Illinois. The lecturer will be Dr. Otto F. Kampmeier, professor emeritus of anatomy, University of Illinois College of Medicine. His subject will be "The Turbulent Rise of Medical Education in Illinois."

Deaths

William Goodell, Evanston, a graduate of the Harvard Medical School, Boston, in 1905, died September 25, aged 82. He was a specialist certified by the American Board of Otolaryngology, a fellow of the American College of Surgeons, and past president of the New England Laryngological Society. In Massachussetts he had been on the staffs of Franklin County Public Hospital in Greenfield, Mass., the Shriners' Hospital for Crippled Children in Springfield and the Springfield Hospital, where he was vice president of the staff.

Herbert E. Hall, retired, Evanston, a graduate of the Northwestern University Medical School in 1906, died February 12, aged 84. He had practiced in Uniontown, Pa., for 51 years before retiring to Evanston in 1957. He was a member of the Pennsylvania Medical Society. In 1922 he did postgraduate work in pediatrics at Harvard University Medical School and was a charter member of the American Academy of Pediatrics.

Frank E. Hansen, retired, Chicago, a graduate of Bennett Medical College in 1906, died February 17, aged 76. He had practiced in Chicago for 45 years and was an ambulance physician for the city until his retirement.

Irving Maurice Harter*, Chicago, a graduate of the University of Illinois College of Medicine in 1933, died November 9, aged 53. He was a member of the American Academy of General Practice.

Lee Gerald Howard*, Chicago, a graduate of the Chicago Medical School in 1938, died February 6, aged 49. He was on the staff at Oak Park Hospital.

James Robert McIntosh, Colfax, a graduate of the Tulane University School of Medicine, New Orleans, in 1926, died January 26, aged 61. He had practiced in Colfax and Bloomington for over 30 years and was a staff member at Brokaw Hospital in Normal, and Mennonite and St. Joseph's hospitals in Bloomington. In 1950-51 he was chief of staff at St. Joseph's. He was a member of the American College of Surgeons and a former consultant at the Illinois Soldiers and Sailors Childrens School in Normal and the Veterans Hospital in Dwight. In World War I he served in the Army and in World War II was a Navy captain attached to the Marine Corps; during the Korean conflict he had tours of duty with the Navy.

John Jerome McIntosh*, Mount Carmel, a *cum laude* graduate of the Northwestern University Medical School in 1905, died January 27, aged 79. He had practiced in Mount Carmel for 56 years. He did postgraduate work in 1906-1907 at Cook County Hospital and at Harvard University Medical School in 1922. In 1924 he studied at Columbia University, Sloan Hospital, and the New York Lying-In Hospital, and in 1928-1929 studied at the Chicago Eye, Ear, Nose, and Throat Hospital. In World War I was a first lieutenant in the Army Medical Corps. For 16 years he was coroner of Wabash County and at one time was oculist for the New York Central Railroad.

He was a Mason and a charter member of the Rotary Club. He was also a member of Alpha Omega Alpha and Phi Beta Pi fraternities, the Wabash County Medical Society, the New York Central Railroad Surgeons Association, and the Northwestern University Medical Alumni Association. He also belonged to the American Legion and the Veterans of Foreign Wars.

Fred C. Rathje, Chicago, a graduate of Rush Medical College in 1905, died June 21, aged 78.

William Turner Rogers, Hume, a graduate of the University of Illinois College of Medicine in 1919, died February 10, aged 71. He had practiced in Carlsbad, N.M., for many years before returning to Hume, his birthplace, in 1960.

Manuel Warsaski, Chicago, a graduate of the University of Illinois Medical School in 1960, died February 9, aged 24, while interning at Cook County Hospital.

**Indicates member of the Illinois State Medical Society*

One Hundred Twenty-first

Annual Meeting



PROGRAM

Illinois State Medical Society

May 14 — 18, 1961

Hotel Sherman **Chicago**

Program Summary

Sunday, May 14

2:00 p.m. Council Meeting
Louis XVI Room

7:00 Credentials Committee
Entrance to Louis XVI Room

7:30 First Meeting of House of Delegates
Louis XVI Room

Monday, May 15

8:00 a.m. Council breakfast
Ruby Room 113

Registration opens

9:00 Reference Committee Meetings

Illinois Obstetrical & Gynecological Society
Gold Room 114

12:00 Exhibits open

12:15 p.m. Illinois Ob-Gyn Luncheon
Old Chicago Room 101

12:30 Administrative Seminar Luncheon
Louis XVI Room

1:30 Section on Eye, Ear, Nose and Throat
Crystal Room

Neurology and Psychiatry Symposium
Assembly Room

2:00 Section on Anesthesiology
Ruby Room 113

Illinois Society of Ob-Gyn
Gold Room 114

6:30 Dinner and Business Meeting, Illinois Chapter, American College of Chest Physicians in Time Room 110

8:30 Fireside Conferences (Chest Physicians)
George Bernard Shaw Room

Tuesday, May 16

8:00 a.m. Council breakfast—Ruby Room

8:30 Auxiliary Pre-Convention Meeting
Orchid Room 106

9:00 Section on Allergy—Gold Room 114

Sections on Cardiovascular Disease and Medicine (combined)
Louis XVI Room

Section on Dermatology
Crystal Room

Section on Obstetrics and Gynecology
Assembly Room

Section on Surgery—Ballroom

9:30 Auxiliary
George Bernard Shaw Room

12:00 noon Preventive Medicine and Public Health Lunch
Life Room 108

12:30 p.m. Luncheons
Dermatology—Gold Room 114
Surgery—Old Chicago Room 101
Illinois Society of Internal Medicine
Louis XVI Room
Fifty Year Club—Assembly Room

1:30 Section on Radiology
Crystal Room

2:00 Section on Preventive Medicine and Public Health
Jade Room 103

Symposium on Hypertension
Louis XVI Room

Auxiliary
George Bernard Shaw Room

6:30 Auxiliary Night Club Tour

7:30 Second Meeting of House of Delegates
Louis XVI Room

Wednesday, May 17

8:00 a.m. Council breakfast—Ruby Room 113

8:30 Auxiliary, Continental Breakfast
George Bernard Shaw Room

8:45 GENERAL ASSEMBLY—Ballroom

9:00 Section on Pediatrics
Crystal Room

9:30 GENERAL ASSEMBLY—Ballroom

10:00 Recess to view exhibits

Auxiliary Round Tables
Gold Room 114; Jade Room 103; Holiday Room 105; Orchid Room 106; Life Room 108; French Room 107; George Bernard Shaw Room

10:30 GENERAL ASSEMBLY—Ballroom

12:15 p.m. Luncheons
Pediatrics—Old Chicago Room 101

12:30 Illinois Academy of General Practice—Assembly Room

Phi Chi—Jade Room 103

Annual Meeting Committee
Room 111

1:00 Auxiliary Lunch and Fashion Show
Ambassador Hotel

1:30 GENERAL ASSEMBLY—Ballroom
Camp Memorial Lecture

2:00 Oration in Medicine

2:30 Oration in Surgery

3:00 Recess to view exhibits

3:30 Office Management Seminar

6:00 Social Hour—Assembly Room

7:00 ANNUAL DINNER—Ballroom

Thursday, May 18

8:00 a.m.	Council breakfast—Ruby Room 113
9:00	Third Meeting of House of Delegates Louis XVI Room
	Section on Pathology Crystal Room
	Physicians Association, Department of Public Welfare Assembly Room
	Auxiliary George Bernard Shaw Room
12:30 p.m.	Luncheons
	Pathology—Old Chicago Room 101
	Auxiliary Installation—Crystal Room
	Council—Jade Room 103
2:00	Illinois Association of Blood Banks Assembly Room
	Exhibits close
3:00	Auxiliary—Orchid Room 106
6:00	Illinois Society of Pathologists' Dinner Jade Room 103

Friday, May 19

9:00 a.m.	Illinois Medical Technologists Crystal Room
12:30 p.m.	Illinois Medical Technologists Lunch Old Chicago Room 101
2:00	Illinois Medical Technologists Crystal Room

Program by Days

Program for Monday, May 15

A.M.

8:00 Council breakfast ..... Ruby Room 113
Registration opens ..... Mezzanine

9:00 Reference Committee Meetings
Reports of officers .... Jade Room 103
Constitutional Committees
..... Orchid Room 106
Council Committees #1 Life Room 108
Council Committees #2 ... Room 107
Constitution and Bylaws
..... Time Room 110
Council Committees # 3
..... Gold Coast Room 111
Council Committees #4
..... Holiday Room 105

Illinois Obstetrical and Gynecological Society

David M. Jenkins, President ..... Bloomington
Deane M. Farley, Secretary ..... Berwyn

MONDAY, MAY 15
Gold Room 114

A.M.

9:00 Business Meeting
9:30 Case Reports
9:50 Hemorrhage Committee Report
Willard Scrivner, East St. Louis
10:10 Toxemia Committee Report,
F. H. Falls, *Professor Emeritus, University of Illinois*
10:30 "Postpartum Hemorrhage," Augusta Webster, *Head of Obstetrics, Cook County Hospital*
11:00 "Incompetent Cervix"
Jack Brodsky, *Champaign*
Carl Greenstein, *Champaign*
11:30 "Review of Infertility in Private Practice"
Philip Lynch, *Decatur*

P.M.

12:15 Luncheon—Old Chicago Room 101
2:00 "Carcinoma of the Cervix and Pregnancy"
A. F. Lash, *Professor of Obstetrics and Gynecology, University of Illinois*
2:45 "Surgical Complications During Pregnancy," Frank Fara, *Head, Department Ob-Gyn MacNeal Memorial Hospital, Berwyn*
3:15 "Maternal Mortality,"
John Rendok
State Department of Public Health

Section on Eye, Ear, Nose and Throat

Wilbur W. Baumgartner, Chairman . . . Kewanee
Richard A. Buckingham, Secretary . . . Chicago

MONDAY AFTERNOON MAY 15
Crystal Room

P.M.

1:30 "Surgical Treatment of Luxated Lens"
E. H. Merz, *Wesley Memorial Hospital*
Burton Zeiger and Irving Puntenney, *VA Research Hospital and Northwestern University*
1:50 Title to be announced
Eugene Folk, Skokie
2:10 "Stapes Surgery: Selection of Patients and the Technique" J. L. Sheehy, *Otologic Medical Group, Los Angeles*
2:55 Recess to view exhibits
3:25 "Surgical Treatment of Cancer of the Larynx" B. J. Soboroff, *University of Illinois College of Medicine*
3:45 "The Temporal Mandibular Syndrome"
G. C. Otrich, Belleville
4:05 Business Meeting

Symposium on Neurology and Psychiatry

Presiding: Louis D. Boshes, Northwestern University Medical School; Michael Reese Hospital

MONDAY AFTERNOON, MAY 15
Assembly Room

P.M.

1:30 "Newer Concepts in the Management of Strokes"
"Medical Aspects," I. C. Sherman
Chicago Medical School; Michael Reese Hospital
"Surgical Aspects," Oscar Sugar
University of Illinois College of Medicine; Illinois Masonic Hospital
"Restorative Aspects," E. E. Gordon
Michael Reese Hospital; Chairman, Rehabilitation Committee, Chicago Heart Association

This presentation is sponsored by the Committee on Aging of the Illinois State Medical Society.

2:20 "Disability and Epilepsy," Alex J. Arieff
Northwestern University Medical School; Passavant Memorial Hospital

2:35 Recess to view exhibits

3:05 "Emotional Problems in Convalescence"
C. K. Aldrich, *University of Chicago School of Medicine*

3:25 "The Doctor, The Patient, and Cancer"
Donald Oken, *Michael Reese Hospital*

3:40 "Present Day Concepts in the Management of the Adolescent"
Eugene I. Falstein, *Michael Reese Hospital*

3:55 "The Challenge of Parkinsonism"
L. D. Boshes, *Northwestern University Medical School; Michael Reese Hospital*

4:15 "The Challenge of Multiple Sclerosis"
H. M. Manfredi, *Stritch School of Medicine, Loyola University; Cook County Hospital*

Section on Anesthesiology

James Felts, Chairman ..... Marion
Freda B. Morgan, Secretary ..... Chicago

Monday afternoon May 15
Ruby Room 113

P.M.

2:00 "Respirators: Are You Fit to Use One?"
R. W. Virtue, *Professor of Anesthesiology, University of Colorado*

"Hypnosis in Anesthesia"
B. V. Wetchler, Peoria

"Re-evaluation of Postoperative Analgesics"
A. T. Shima, Oak Park

21st Annual Meeting Illinois Chapter American College of Chest Physicians

Monday evening, May 15
George Bernard Shaw Room

P.M.

6:30 Dinner and Business Meeting, Time Room 110

8:30 Fireside Conferences

Note: These conferences are informal and offer an opportunity for free discussion. Discussion leaders will be seated at tables with proper identification. Physicians may participate in the discussion of their choice and may move on to other subjects when and if they desire.

1. Pediatric Cardiology
Moderator: Maurice Lev, Chicago
T. G. Baffes, Chicago; D. E. Cassels, Chicago
J. R. Christian, River Forest; B. M. Gasul, Chicago
B. L. Lendrum, Milton Weinberg, Jr., Chicago

2. Thoracic Emergencies
Moderator: J. R. Head, Chicago
W. H. Eastman, Peoria; K. C. Johnston, Chicago
J. L. Keeley, Chicago; W. M. Lees, Chicago
M. S. Sadove, Chicago; E. B. Sanborn, Chicago
D. H. Trumpe, Springfield

3. Congestive Heart Failure
Moderator: J. T. Sharp, Hines
V. T. Austin, Urbana; H. A. Bliss, Chicago
T. Z. Polley, Joliet; G. A. Smyth, Chicago
H. A. Flack, Chicago

4. Acute Myocardial Infarction
Moderator: W. H. Phelan, Chicago
R. J. Jones, Chicago; Paul Kedzie, Chicago
V. C. Keeling, Rockford; C. C. Maher, Chicago
E. J. O'Donovan, Chicago; J. G. Schlichter, Chicago

5. Chemotherapy and Tuberculosis
Moderator: K. H. Pfeutze, Chicago
LeRoy Berard, Chicago; K. G. Bulley, Aurora
T. W. Lester, Jr., Hinsdale; D. F. Loewen, Decatur
M. R. Lichtenstein, Chicago; C. K. Petter, Waukegan

6. Pulmonary Emphysema
Moderator: R. W. Carton, Chicago
G. S. Berg, Forest Park; J. M. Head, Chicago
M. A. Kaplan, Chicago; G. L. Snider, Chicago
Leon Unger, Chicago; Q. D. Young, Chicago

7. Asymptomatic Lung Disease
Moderator: D. B. Radner, Chicago
Abel Froman, Chicago; S. A. Levinson, Chicago
David Reisner, Hines; H. A. Schorsch, Chicago

8. Cardiac Surgery
Moderator: E. H. Fell, Chicago
H. E. Bolton, Chicago; Arthur DeBoer, Chicago
O. C. Julian, Chicago; F. J. Lewis, Chicago
P. V. Moulder, Chicago; L. H. Rubenstein, Chicago

9. Occupational Diseases of the Chest
Moderator: Andrew L. Banyai, Chicago
I. Pilot, Chicago; O. A. Sander, Milwaukee, Wis.
E. L. Walsh, Chicago; J. R. Winston, Chicago

10. Pericardial and Pleural Diseases
Moderator: S. K. Sweany, Hines
W. B. Buckingham, Chicago; H. J. Isaacs, Chicago
W. F. Kellow, Chicago; A. H. Niden, Chicago
R. C. Oldfield, Jr., Oak Park

11. Cancer of the Lung
Moderator: W. E. Adams, Chicago
R. J. Gottlieb, LaGrange; I. M. Greenberg, Chicago
P. H. Holinger, Chicago; G. W. Holmes, Chicago
R. J. Jensik, Chicago; S. A. Mackler, Chicago
J. R. Thompson, Chicago

12. Non-Tuberculous Pulmonary Infections
Moderator: M. H. Lepper, Chicago
J. J. Brosnan, Chicago; T. R. Hudson, Chicago
J. H. Huss, Elmhurst; A. E. Livingston, Bloomington
E. T. McEnery, Chicago; Irving Mack, Chicago
R. S. Mendelsohn, Chicago

13. Pulmonary Function Testing
Moderator: A. H. Andrews, Chicago
D. W. Cugell, Chicago; R. T. Fox, Evanston
B. L. Gordon, Chicago; R. C. Kory, Wood, Wis.
E. R. Levine, Chicago; J. F. Perkins, Jr., Chicago

14. Home Treatment of Tuberculosis
Moderator: E. A. Piszczek, Forest Park
C. F. Hall, Springfield; L. J. Miller, Chicago
Dan Morse, Peoria; J. B. Novak, Chicago
Joseph Taymor, George Turner, Chicago

Program for Tuesday, May 16

A.M.
8:00 Council breakfast ..... Ruby Room 113
8:30 Auxiliary pre-convention meeting
Orchid Room 106

Section on Allergy

Robert J. Becker, Chairman ..... Joliet
I. A. Fond, Secretary ..... Chicago

Tuesday morning, May 16
Gold Room 114

A.M.
9:00 "Skin Tests With New Microbacterial Products"
M. R. Lichtenstein, *University of Illinois College of Medicine*
"Problems in the Administration of Foreign Serum and Penicillin to the Allergic Patient"
Roy Patterson, *Northwestern University Medical School*
"Reaction to Antibiotics"
T. R. Sherrod, *University of Illinois College of Medicine*
"The Status of Repository Therapy Today"
C. E. Arbesman, *University of Buffalo School of Medicine; Chief of Allergy Clinic and Director of the Allergy Research Laboratory, Buffalo General Hospital*

Combined Sections on Cardiovascular Disease and Medicine

Cardiovascular Section
Theodore Z. Polley, Chairman ..... Joliet
Gerry A. Smyth, Secretary ..... Chicago
Medicine Section
Richard Allyn, Chairman ..... Springfield
Edward J. Wiss, Secretary ..... Chicago

Tuesday morning, May 16
Louis XVI Room

A.M.
9:00 (Program to be announced)
P.M.
12:30 Illinois Society of Internal Medicine Lunch — Louis XVI Room

Section on Dermatology

Marcus R. Caro, Chairman ..... Chicago
Myron H. Kulwin, Secretary ..... Champaign

Tuesday morning, May 16
Crystal Room

A.M.
9:00 "Dermatologic Manifestations of Internal Diseases" (Lantern slides)
Speaker: M. R. Caro, *Chicago*
Panel: H. F. Dowling, *University of Illinois College of Medicine*
H. J. Zimmerman, *Chicago Medical School*
10:00 Recess to view exhibits
10:30 "Pediatric Dermatology" (Lantern slides)
Speaker: J. R. Haserick, *Director, Dermatology Department, Cleveland Clinic*
Panel: J. A. Bigler, *Northwestern Medical School*
M. P. Borovsky, Chicago *Medical School*
J. R. Christian, *Stritch School of Medicine, Loyola University*
H. N. Sanford, *University of Illinois College of Medicine*
12:00 Business Meeting
P.M.
12:30 Luncheon in Gold Room 114

Section on Obstetrics and Gynecology

Co-Sponsored by Sections on Preventive Medicine and Public Health, and Pediatrics

Michael Boley, Chairman ..... Chicago
Robert R. Hartman, Secretary ..... Jacksonville

Tuesday morning May 16
Assembly Room

A.M.
9:00 "The Clinical Applications of a Detailed Five Year Perinatal Mortality Study"
J. H. Williams, *Head of the Perinatal Institute, Medical School, Ohio State University*
9:45 Round Tables
Moderator: Samuel Andelman, Chicago

"Metabolic Disturbances"
Marvin Cornblath, *Northwestern University School of Medicine; Michael Reese Hospital*
C. P. McCartney, *University of Chicago*
J. P. Birge, *Illinois Department of Public Health*
Fred Long, *Peoria City-County Health Departments*

"Erythroblastosis"
D. H. Welker, *Grant Hospital, Chicago*
J. J. H. Kampinga, *Grant Hospital, Chicago*
W. J. Cassel, *Jackson County Health Department, Murphysboro*
J. B. Hall, *Cook County Health Department*

"Anesthesia and Analgesia"
R. E. Dukes, *Carle Hospital Clinic, Champaign*
Carl Greenstein, Obstetrician, Champaign
Edward Press, *Evanston City Department of Health*
H. J. Banton, *Illinois Department of Public Health, Champaign*

"Bleeding Accidents and Anemia"
H. S. Traisman, *Northwestern University Medical School; Children's Memorial Hospital*
H. L. Penning, *St. John's and Memorial hospitals, Springfield*
J. H. Rendock, *Illinois Department of Public Health, Springfield*
C. A. Lang, *DuPage County Health Department, Wheaton*

"Prenatal Care"
P. C. Tracy, *Children's Memorial Hospital and Resurrection Hospital, Chicago*
R. E. Bucher, Obstetrician, Danville
W. M. Hanrahan, *Cook County Department of Public Health*
A. G. Baker, *Lake County Health Department, Waukegan*

"Perinatal and Neonatal Infections"
A. C. Rambar, *Michael Reese Hospital*
L. A. Carrow, *Northwestern University School of Medicine; Chicago Wesley Memorial Hospital*
H. S. Miller, Health Officer, Winnetka-Glencoe
D. F. Rawlings, *Illinois Department of Public Health, Springfield*

11:00 Recess to view exhibits
11:30 Business Meeting

Section on Surgery

Harold P. McGinnes, Chairman .... Bloomington
William M. Lees, Secretary ..... Chicago

TUESDAY MORNING, MAY 16
Ballroom

A.M.
9:00 "Special Problems Relating to Surgery in Patients Over 70 Years of Age"
MODERATOR: H. P. McGinnes, Bloomington
Panel: A. Wagner, Internist, Evanston
Max Sadove, Anesthesiologist, *University of Illinois Hospital*
E. L. Strohl, Surgeon, Chicago
E. T. Wilson, Urologist, Chicago
"Special Problems Relating to the Management of the Cancer Patient and His Family"
MODERATOR: W. M. Lees, Chicago
Panel: D. P. Slaughter, Chicago
The Rev. Dr. Harold Martin, *Second Presbyterian Church, Bloomington*
The Very Rev. J. W. Stafford, C.S.V., *Arlington Heights*
Rabbi Karl Weiner, *Temple Judea of Niles Township, Skokie*

P.M.
12:30 Surgery Lunch in Old Chicago Room 101

Section on Preventive Medicine and Public Health

Co-Sponsored by Sections on Obstetrics and Gynecology and Pediatrics

Herbert Ratner, Chairman ..... Oak Park
John B. Hall, Secretary ..... Chicago

TUESDAY AFTERNOON, MAY 16
Jade Room 103

A.M.
12:00 Lunch in Life Room 108
Section in Preventive Medicine and Public Health;
Illinois Association of Medical Health Officers;
Illinois Academy of Preventive Medicine;
Illinois Chapter of American Association of Public Health Physicians
"Reflections on Modern Medicine"
R. L. Jackson, *University of Missouri*

P.M.
2:00 "The Current Status of Breast Feeding"
MODERATOR: Herbert Ratner
Panel: R. L. Jackson, Pediatrician, Columbia, Mo.
E. R. Kimball, Jr., Pediatrician, Evanston

H. F. Meyer, Pediatrician, Chicago
W. C. Scrivner, Obstetrician, East St. Louis
Mrs. Marion Tompson, *La Leche League*, Franklin Park
G. J. White, General Practitioner, River Forest

Section on Radiology

Abram H. Cannon, Chairman ..... Chicago
Homer Van Landingham, Secretary .... Rockford

TUESDAY AFTERNOON, MAY 16
Crystal Room

P.M.
1:30 "The Acute Abdomen," W. R. Eyler
Chairman of Radiology Department, Henry Ford Hospital, Detroit
3:00 Recess to view exhibits
3:30 Film Reading Session
MODERATOR: Dr. Eyler

Symposium on Hypertension

Sponsored by Wallace Laboratories

TUESDAY AFTERNOON, MAY 16
Louis XVI Room

P.M.
2:00 "Current Status of the Management of Hypertension"
MODERATOR: P. J. Talso, *Stritch School of Medicine, Loyola University; Mercy and Cook County hospitals*
Panel: C. W. Crumpton, *Chairman, Cardiovascular Research Laboratory, University of Wisconsin Medical School*
Edward Willoughby, *University of Illinois Medical School; Hines V.A. Hospital*
J. G. Janney, Jr., *Director of Section on Cardiology, St. Louis University Medical School*

Program for Wednesday, May 17

A.M.
8:00 Council Breakfast ..... Ruby Room 113
8:30 Auxiliary, Continental Breakfast
George Bernard Shaw Room

General Assembly

WEDNESDAY MAY 17, *in Ballroom*

Presiding: Andrew J. Brislen, First Vice President

A.M.
8:45 "Radiation: Physician and Patient"
MODERATOR: C. E. Clark, Sycamore
Panel: P. C. Hodges
R. S. Landauer, Sr.

10:00 Recess to view exhibits

Presiding: H. Close Hesseltine, President

10:30 "Acute Abdominal Diseases in Medicine and Surgery"
MODERATOR: W. H. Cole, *University of Illinois College of Medicine*
Panel: Manuel Lichtenstein, *Cook County Post Graduate School*
Edmond Foley, *University of Illinois College of Medicine*
Earl Barth, *Northwestern University School of Medicine*
Heyworth Sanford, *University of Illinois College of Medicine*

Presiding: H. Close Hesseltine, President

P.M.
1:30 CAMP MEMORIAL LECTURE
"The Facts of Life in the Future of Medicine"
John B. Reckless, *Department of Psychiatry, Duke University Medical Center, Durham, N.C.*

2:00 Oration in Medicine
"Human Factors in Jet and Space Flight"
Lt. Col. Charles A. Berry, *Aerospace Medicine Division, USAF*
Co-sponsored by Illinois Society of Internal Medicine

2:30 Oration in Surgery
"Control of Ovulation: Methods, Merits and Demerits"
John Rock, *Professor Emeritus of Gynecology, Harvard University*

3:00 Recess to view exhibits

Presiding: Clinton D. Swickard, Second Vice President

3:30 Office Management Seminar
"Profitable Practice Pointers"
Mr. Wheeler Chapman, Medical Business Consultants
Mr. Elbert Cooper, Professional Management

6:00 Social Hour—Assembly Room

7:00 Annual Dinner—Ballroom
"This, Too, Is the Practice of Medicine"
Mr. T. C. Petersen, *Director of Program Development, American Farm Bureau, Chicago*

Section on Pediatrics

Edmond R. Hess, Chairman ..... Chicago
Carl E. Sibilsky, Secretary ..... Peoria

Wednesday morning, May 17 *in Crystal Room*

A.M.

9:00 "Familial Craniosynostosis (Crouzon's Disease)"
Walter Whitaker, Quincy

9:20 "Hemodialysis (The Artificial Kidney) in Barbiturate and Salicylate Intoxication"
Harvey Buchman, *Michael Reese Hospital, Chicago*

9:40 "Management of Pectum Excavatum"
Arthur DeBoer, *Children's Memorial Hospital, Chicago*

10:00 "Early Treatment of Scoliosis"
W. P. Blount, *Head of Department of Orthopedics, Marquette University, Milwaukee*

10:30 Recess to view exhibits

11:00 "Cardio-Respiratory Emergencies in the Newborn"
Robert Miller, *Children's Memorial Hospital, Chicago*

11:20 "Common Sense Approach to the Care of the Retarded Child"
Robert Kugel, *Director of the Child Development Clinic, State University of Iowa*
Co-sponsored by Illinois Chapter, American Academy of Pediatrics

11:50 Business Meeting and Election of Officers

P.M.

12:15 Luncheon—Old Chicago Room 101 Section on Pediatrics and Illinois Chapter, American Academy of Pediatrics

Program for Thursday, May 18

A.M.

8:00 Council Breakfast . . . Ruby Room 113

9:00 Third Meeting of House of Delegates
Louis XVI Room
Auxiliary in George Bernard Shaw Room
Section on Pathology—Crystal Room
Physicians Association of Department of Public Welfare—Assembly Room

12:30 Auxiliary Installation Luncheon—Crystal Room
Pathology Luncheon—Old Chicago Room 101
Council Luncheon—Jade Room 103

P.M.

2:00 Exhibits Close

3:00 Auxiliary—Orchid Room 106

6:00 Illinois Society of Pathologists Dinner
Jade Room 103

Section on Pathology

Paul Van Pernis, Chairman ..... Rockford
J. Robert Thompson, Secretary.....Chicago

Thursday morning, May 18, *Crystal Room*

A.M.

9:15 "Bacteriologic Problems in a General Hospital"
J. W. King, *Cleveland Clinic*

10:00 "Staphylococcal Pneumonias from the Radiologists' Standpoint"
T. A. Heenahan, *Community Hospital, Geneva; Sherman Hospital, Elgin*

10:30 Recess to view exhibits

11:00 "Gram Negative Infections"
Walter Wood, *Cook County Hospital; University of Illinois College of Medicine*

12:00 Luncheon and business meeting

Illinois Association of Blood Banks

President, Donald R. Russ, M.D. .....Chicago
Secretary, Morris Goldenberg, M.D. .... Chicago

THURSDAY AFTERNOON, MAY 18, *Assembly Room*

P.M.

2:00 "Microbiology in the Blood Bank"
J. W. King, M.D., *Cleveland Clinic*

2:15 Discussion with Dr. King

2:30 "Donor Recruitment and Blood Replacement Policies in Illinois"
Moderator:
John E. Maloney, M.D., *Bloomington*
Panel:
Jeff Jones, *Peoria Regional Red Cross Center*
Paul Van Pernis, M.D., *Northern Illinois Blood Bank, Rockford*
William J. Kyler, *Aurora Blood Bank and Donor's Society*
Max Appel, M.D., *Burnham City Hospital, Champaign*
Mrs. Carol Grabowski, *Mt. Sinai Blood Center, Chicago*

3:30 Annual Business Meeting

Program for Friday, May 19

A.M.

9:00 Illinois Medical Technologists
Crystal Room

P.M.

12:30 Illinois Medical Technologists Lunch
Old Chicago Room 101

2:00 Illinois Medical Technologists
Crystal Room

The Handbook for Delegates

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ANNUAL MEETING

MAY 14-18, 1961

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J. S. Schriver	James Fink
Chester L. Crean	C. K. Jones
Philip R. McGuire	Robert Jensik
Edward C. Helfers	Eugene J. Ranke
W. B. Stromberg, Sr.	Irving Perrill
Karl L. Vehe	Russell Elmer
Joseph R. DeCaro	Harry Carter
W. O. Ackley	Philip M. Bedessem

North Side Branch

Michael Boley	Coye C. Mason
Henri DuVries	Roland R. Cross
S. L. Andelman	Vincent C. Freda
William Hutchison	David Slight
John R. Wolff	Samuel A. Levinson
Jack Williams	B. F. Lounsbury
James H. Cross	G. L. Kaufmann
Clifton L. Reeder	Leander W. Riba

North Suburban Branch

Robert A. Snyder	Donald E. Hansen
Harold C. Lueth	Warren C. Jenkins
C. Malcolm Rice, Sr.	Paul L. Bedinger
John L. Savage	Luella Nadelhoffer
Edson F. Fowler	William H. Harridge
Herbert S. Miller	William Cummings
Noel G. Shaw	Frank Pirruccello
Raymond H. Conley	Jerome T. Paul

Northwest Branch

S. M. Goldberger	Matthew Uznanski
N. J. Kupferberg	Louis A. Wajay
M. J. Kutza	M. A. Rydelski
A. J. Linowiecki	James McDonnough
F. M. Nicholson	L. S. Sluzynski
Peter N. Furno	R. V. Kochanski

South Chicago Branch

S. J. Sullivan	John B. Condon
Mayrand Shapiro	Billie B. Hennan
Casper Epsteen	John Marlowe
Carl Y. Werelius	Raymond White

South Side Branch

Quentin Young	Jacob Epstein
Robert R. Mustell	Maurice Gleason

Southern Cook County Branch

Herbert Jansen	C. Dale Collins
Walter Miller	Luke R. Pascale

Stock Yards Branch

Glenn A. Burckart	E. W. Szczurek
E. J. Lukaszewski	Joseph M. Ruda

West Side Branch

George Kaiser	Eugene T. Hoban
Anna Marcus	Lawrence Ryan
Joseph F. O'Malley	Louis S. Varzino
Eugene T. McEnery	John Gregorio

At-Large

Norris J. Heckel
Edwin F. Hirsch
George C. Turner
Theodore R. Van Dellen
Patrick H. McNulty
Allison L. Burdick, Sr.

AGENDA FOR MEETINGS OF THE HOUSE OF DELEGATES

FIRST MEETING: SUNDAY EVENING MAY 14, 1961 LOUIS XVI ROOM—7:30 P.M.

1. Call to order by the president — H. Close Hesseltine
2. Report of the Committee on Credentials — Allison L. Burdick, Chairman
3. Roll call by the secretary — Jacob E. Reisch
4. Presentation of Outstanding General Practitioner Award
   To: William E. Carnahan of Macomb
   By: The President, H. Close Hesseltine
5. Approval of the minutes of the May, 1960 meetings of the House as published in the August and September issues of the Illinois Medical Journal.
6. Appointment of reference committees by the president.
7. Consideration of annual reports as published in the April issue of the Illinois Medical Journal — with supplementary reports as desired
8. Unfinished business
9. New business
   a. Introduction of resolutions and referring of same to proper reference committees
   b. Other new business
10. Adjournment

SECOND MEETING: TUESDAY EVENING
MAY 16, 1961
LOUIS XVI ROOM—7:30 P.M.

1. Call to order by the president — H. Close Hesseltine
2. Report of the Committee on Credentials — Allison L. Burdick, Chairman
3. Roll call by the secretary — Jacob E. Reisch
4. Reading and approval of minutes of previous session, or action to postpone
5. Selection of meeting place for 1964 annual meeting
6. Reports of reference committees and action thereon
   a. Reports of Officers, Councilors, etc.
      Paul A. Dailey, Chairman
   b. Constitutional Committees
      H. Kenneth Scatliff, Chairman
   c. Constitution and Bylaws
      Wm. H. Schowengerdt, Chairman
   d. Council Committees No. 1
      Wm. H. Whiting, Chairman
   e. Council Committees No. 2
      John R. Wolff, Chairman
   f. Council Committees No. 3
      Edwin F. Hirsch, Chairman
   g. Council Committees No. 4
      Charles Allison, Chairman
7. Unfinished business
8. New business
   a. Communications
   b. Election of Emeritus members
   c. Election of Retired members
   d. Other new business
9. Adjournment

THIRD MEETING: THURSDAY MORNING
MAY 18, 1961
LOUIS XVI ROOM—9:00 A.M.

1. Call to order by the president — H. Close Hesseltine
2. Report of the Committee on Credentials — Allison L. Burdick, Chairman
3. Roll call by the secretary — Jacob E. Reisch
4. Reading and approval of minutes of previous session, or action to postpone
5. Announcement of awards to Scientific Exhibitors — Coye C. Mason, Director and Chairman of Scientific Exhibits
6. Election of Officers
   a. President Elect (CMS)
   b. First Vice President (downstate)
   c. Second Vice President (CMS)
   d. Secretary-Treasurer
   e. Presiding officer
      (Elected annually to serve a term of one year)
   f. Alternate Presiding officer
      (Elected annually to serve a term of one year)
7. Election of Councilors

District	*Terms expiring*
Third District	William E. Adams
	John Lester Reichert
Fourth District	Fred C. Endres
Fifth District	Jacob E. Reisch
Seventh District	Arthur F. Goodyear
Eighth District	Harlan English

8. Election of Delegates to the American Medical Association
   (To take office on Jan. 1, 1962, and serve for a term of two years)

   Terms expiring on Dec. 31, 1961

H. Kenneth Scatliff	(CMS)
Walter C. Bornemeier	(CMS)
Frank H. Fowler	(CMS)
Arthur F. Goodyear	(downstate)
Harlan English	(downstate)
Joseph T. O'Neill (deceased)	(downstate)

9. Election of Alternate Delegates to the American Medical Association
   (To take office on Jan. 1, 1962, and serve for a term of two years)

   Terms expiring on Dec. 31, 1961

Eugene T. McEnery	(CMS)
George C. Turner	(CMS)
E. A. Piszczek	(CMS)
Jacob E. Reisch	(downstate)
Norman L. Sheehe	(downstate)

10. Election of members of Standing (Constitutional) Committees
    a. Grievance Committee
       (Two members elected each year for a three year term)
       Terms expiring:

Arkell M. Vaughn	(CMS)
Willis I. Lewis	(downstate)

    b. Medical Benevolence Committee
       (One member elected each year for a three year term)

Term expiring:
Norman L. Sheehe (downstate)

c. Medical Education and Hospitals
(Three members elected each year for a one year term)
Terms expiring:
Kenneth C. Johnston (CMS)
Ward Eastman (downstate)
George F. O'Brien (CMS)

d. Medico Legal Committee
(Two members elected each year for a three year term)
Terms expiring:
Leo P. A. Sweeney (CMS)
F. E. Bihss (downstate)

e. Committee on Medical Testimony
(Two members elected each year for a four year term)
Terms expiring:
Joseph F. O'Malley (CMS)
William K. Ford (downstate)

f. Committee on Prepayment Plans and Organizations
(One elected each year for a three year term)
Term expiring:
Harry E. Mantz (downstate)

11. Fixing of per capita assessment for membership in 1962
12. Any additional reports of reference committees not presented at the second meeting of the House of Delegates held on Tuesday, May 16
13. Unfinished business
14. New business
15. Induction of president elect, Edwin S. Hamilton, into the office of president of the Illinois State Medical Society by the retiring president, H. Close Hesseltine
16. Adjournment, sine die

COMMITTEES
FOR 1961 HOUSE OF DELEGATES

Committee on Credentials

Foyer of the Louis XVI Room
(1) Sunday, May 14 at 7:00 p.m.
(2) Tuesday, May 16 at 7:00 p.m.
(3) Thursday, May 18 at 8:30 a.m.

Allison L. Burdick, Sr., Chairman	CMS
William H. Walton	St. Clair County
M. R. Saxon	Kendall County
Karl L. Vehe	CMS

Committee on Attendance

This committee will distribute and collect attendance slips, voting slips, supplementary reports, reports of reference committees, etc., for members of the House, and also act as Sergeants at Arms if necessary.

E. J. Lukaszewski, Chairman	CMS
M. J. Kutza	CMS
S. M. Goldberger	CMS
James H. Rutledge	Pike County
William G. Thomas	DeKalb County

Reference Committee on Reports of Officers, Councilors, AMA Delegates, and the Illinois Medical Journal

This committee will meet in the Jade Room No. 103 on Monday morning, May 15, at 9 o'clock, to consider and report on the reports of
The President
The President Elect
1st Vice President
2nd Vice President
Secretary-Treasurer
Executive Administrator
Councilors of the Eleven Councilor Districts
Councilor-at-Large
Delegates to the A.M.A.
Editor, Illinois Medical Journal
Journal Committee
Editorial Board

Paul A. Dailey, *Chairman*	Greene County
Jean W. Moore	Vermilion County
George H. Woodruff	Will Grundy County
Noel G. Shaw	CMS
Charles P. McCartney	CMS

Reference Committee on Reports of Constitutional Committees

This committee will meet in the Orchid Room No. 106 on Monday morning, May 15, at 9 o'clock to consider and report on the reports of

Committee on Archives
Benevolence Committee
Grievance Committee
Committee on Medical Education and Hospitals
Committee on Medical Service
Committee on Medical Testimony
Medico Legal Committee
Committee on Prepayment Plans and Organizations
Committee on Public Relations

H. Kenneth Scatliff, *Chairman*	CMS
Joseph C. Sodaro	CMS
James H. Cross	CMS
Carl F. Neuhoff	Peoria County
Maurice D. Murfin	Macon County

Reference Committee on Reports of Constitution and Bylaws Committee

This committee will meet in the Time Room No. 110 on Monday morning, May 15, at 9 o'clock to consider and report on the suggested changes in the Constitution and Bylaws.

William H. Schowengerdt, *Chairman*	Champaign County
Thomas F. Harmon	Sangamon County
Frank Kwinn	CMS
Casper M. Epsteen	CMS
Keith H. Frankhauser	Fulton

Reference Committee on Reports of Council Committees No. 1

This committee will meet in the Life Room No. 108 on Monday morning, May 15, at 9 o'clock to consider and report on the reports of

Advisory Committee on Dependents Medical Care (Medicare)
Advisory Committee, IPAC
Advisory Committee—Medical Assistants Association
Advisory Committee on Governmental Medical Services
American Legion
Civil Defense
Coroners Act
Selective Service
Veterans Administration
Advisory Committee to the Woman's Auxiliary
Report of the President of the Auxiliary

William H. Whiting, *Chairman*	Union County
G. E. Hartenbower	McLean County
Kenneth H. Keeton	Adams County
Harold C. Lueth	CMS
F. A. Tworoger	CMS

Reference Committee on Reports of Council Committees No. 2

This committee will meet in Room 107 on Monday morning, May 15, at 9 o'clock to consider and report on the reports of

American Medical Education Foundation
Committee on Aging
Ad Hoc Committee — "Over 65"
Ad Hoc Committee — Mills-Kerr Bill
Committee on Cancer
Committee on Cardiovascular Disease
Ethical Relations Committee
Committee on Eye Health
Fifty Year Club Committee
Committee on Impartial Medical Testimony

John R. Wolff, *Chairman*	CMS
Eugene T. McEnery	CMS
L. M. Mammoser	CMS
George B. Callahan	Lake County
Robert R. Hartman	Morgan County

Reference Committee on Reports of Council Committees No. 3

This committee will meet in the Gold Coast Room No. 111 on Monday morning, May 15, at 9 o'clock to consider and report on the reports of

Interprofessional Council
Maternal Welfare Committee
Medical Economics Committee
Committee on Membership
Committee on Mental Health
Liaison Committee, Illinois Bar Association
Liaison Committee, Illinois Hospital Association
Committee on Narcotics
Committee on Nursing
Committee on Nutrition

Edwin F. Hirsch, *Chairman*	CMS
Robert R. Mustell	CMS
Warren W. Young	CMS
William K. Ford	Winnebago County
N. A. Thompson	Saline County

Reference Committee on Reports of Council Committees No. 4, and Miscellaneous Business

This committee will meet in the Holiday Room No. 105 on Monday morning, May 15, at 9 o'clock to consider and report on the reports of

Committee on Occupational Health
Permanent Home Committee
Committee on Physically Handicapped Children
Committee on Poliomyelitis Control
Committee on Postgraduate Medical Education and Scientific Service
Committee on Rural Health & Student Loan Fund
Committee on School Health
Committee on Traffic Safety
Committee on Tuberculosis Control
Committee on Radiation
Committee to Study Postgraduate Education
Ad Hoc Committee on the Springfield Office

Charles Allison, *Chairman*	Kankakee County
E. F. Moore	Madison County
Darrell H. Trumpe	Sangamon County
A. J. Brislen	CMS
L. S. Tichy	CMS

TAKE PART IN

POLICY-MAKING

ACTIVITIES

. . . . . *Before* May 14 . . . . .

Select the

Reference Committee Meetings

YOU will attend

——————BRING YOUR JOURNAL——————

NOTES

Reports of Officers and Committees

THE REPORT OF THE PRESIDENT

To become president of your organization is a very special honor. The duties of the office engulf the individual like a maelstrom almost before he is aware of them. I shall cherish throughout my days your confidence and trust in me. My creed remains as it was before: to work with and for the Illinois State Medical Society when and as you desire, and I will yield willingly any time as you direct. This year has been wonderful. I shall always remember it with warm affection.

Like time and environment, the Illinois State Medical Society is in a changing state. But to remain static means that one will be bypassed and left in a state of confusion because of attainments of others more progressive. Our past is documented with periods of growth and activity that have waxed and waned; but inevitably, we marched forward. Throughout our existence our House of Delegates, our Council, and our officers have performed their routine duties. They have risen also to meet emergencies and crises. As need is the mother of invention, so crises and challenges are productive of greatness. On that basis, the Illinois State Medical Society should be in the era of considerable growth. Whatever history records of our Society this year, it will indicate major adminstrative, educational, and reorganizational changes occurred with a minimum of frustration and a maximum of speed. Socio-economic and medico-legislative problems have become major issues. At the same time, we have had to keep abreast of advances in medicine and the medical sciences that are producing an unparalleled revolution in the care of our citizens.

During 1960-61 your officers, your Council, your various committees (both Constitutional and Council committees) functioned properly. Reports from these sources are before you. It is urged that you review all of them. Your attention is called particularly to the Ad Hoc Committee which the House of Delegates requested last year. It was appointed by the president as you directed to review the "over-65 insurance program." This committee was composed of three members of the House of Delegates and three members from the Council, in compliance with the direct wishes of the House.

Reference committees have been appointed with the cooperation of the president elect, Dr. Hamilton, the chairman of the Council, Dr. Piszczek, the secretary-treasurer, Dr. Reisch, and others.

Your president will have been the guest of the following state medical societies at their annual meetings: the Michigan State Medical Society, the Kentucky State Medical Association, the Indiana State Medical Association, the Iowa State Medical Society, the Missouri State Medical Association, and the State Medical Society of Wisconsin. Your president has been the guest at a number of other meetings, including the Illinois Bar Association, the Illinois State Dental Society, the Illinois Agricultural Association, the Health Improvement Association, and the Illinois Nursing Association. He has attended meetings of the Council and others which he was expected to attend. Furthermore, your president has fulfilled a number of speaking engagements to present the views of medicine before medical and lay groups. At the request of the Decatur Review, a special article was written pointing out what medicine has done and is doing.

Our immediate past president and Councilor-at-Large, Dr. Joseph T. O'Neill, succumbed to chronic illness on Saturday, February 25. He worked faithfully for the Illinois State Medical Society as long as he was able to do so. Even when he was limited in his activities, his interest and concern continued. He anticipated, somewhat, the future by preparing his reports.

Last year at my induction, I pointed out that there were a number of physicians in Illinois who were not members of our Society. There are almost 2,000 licensed physicians in Cook County not in our membership. Most of these must be ethically and otherwise qualified for membership. Elsewhere in the state there are eligible nonmembers. We should not lower our standards in the slightest; yet anyone who can qualify should be in organized medicine.

During the year problems have arisen regarding internships and residencies, particularly of foreign graduates. By the establishment of standards of examination, this matter is being resolved.

No doubt the members of our Society share the concern of your officers and councilors about legislation leading to socialized medicine. It exists not because of partisan politics but because of the philosophy of some officials. One position we must hold: Only that which will be sound for the public immediately and in the future can be appropriate for our profession. Some of the proposed legislation would downgrade or impair the care and quality of medical services.

The financial status of your Society is better than had been projected in the budget for the year beginning May, 1960. There is in prospect a proposed change in our fiscal year from May 1 to April 31, to conform to the calendar year. There are merits in this because it would parallel the dues income.

Your president would like to acknowledge particularly the faithfulness and active support of the president elect, Dr. Hamilton, the first vice president, Dr. Brislen, the second vice president, Dr. Swickard, and the secretary-treasurer, Dr. Reisch. In addition, the chairman of the Council, Dr. Piszczek, always has been available and helpful. He assumed an active role with vigor and tirelessness. Inasmuch as it is not practical to give commendation to the many who deserve it, let it be recorded that we are a healthy and united Society and possess a remarkably able staff.

Your delegates to the American Medical Association and their alternates have carried out your requests. Illinois has had a resident trustee on the AMA Board for many years. We salute the current trustee, Dr. Percy E. Hopkins, a logical thinker, faithful servant, and a most valuable friend of medicine.

With objective analysis, one must admit that the reorganization of the state society's office and the employment of new personnel have progressed more rapidly than anticipated. Mr. Robert L. Richards and his staff are cooperative, diligent, and a united force for Illinois medicine. They possess ability, energies, and competence of which we can be proud. This staff, with one of the officers, visited each councilor district to acquaint the membership with our reorganization and to explain how our Society could better serve the rank and file. Mr. Richards and his staff are the forces to carry out the policies, decisions, and directions of the House of Delegates, the Council, and the officers.

Matters of policy, decisions, and judgment rest with the House of Delegates, the Council, and your officers. The House normally determines policy. In the interim between meetings, because of time factors or an acute crisis, immediate decisions by the Council may be necessary. There are times when a decision, if not made, would harm the medical profession or endanger the public welfare.

The members of the House of Delegates naturally expect their leaders to serve in the best possible fashion. They would act reluctantly on policy matters, but they would be objective and fair. The history of our Society reveals that when these instances have arisen, our leaders have performed creditably. The Council is a creature of the House of Delegates, and to it you assign the administrative and judicial responsibilities.

Tribute must be given to the Woman's Auxiliary too for its endeavors and strong support.

Your president intends to make a short supplementary report, particularly some recommendations. These recommendations may be modified by changes in events by the time of the annual meeting.

One item concerns our "image." Since requests are being received in increasing numbers for speakers before medical societies, civic organizations, and lay groups, it is desirable to have some method for guidance and for procuring appropriately competent representatives of medicine to appear before such groups, especially in areas in which the atmosphere may be unfriendly to medicine. We must not only safeguard our "image" but also tell our story.

The recommendation will not interfere with individual rights. It refers to those who officially or unofficially represent the Illinois State Medical Society. It is hoped that all of our members will bear in mind their privileges and duties to be ambassadors.

A second concern centers on the point of missionary work for membership. A third item relates to the desirability of physicians to become more active in civic and local projects as individual citizens. A fourth subject emphasizes the need to be oriented in and to deliver good public relations. The fifth matter concerns responding

to communications. There may be other items.

The successes and accomplishments of this year are the results of the activities of the chairman and the committees, the councilors, and the officers. All matters which fell short, caused a disservice or merely a disappointment, belong upon the president's shoulders. The president should assume these because if he takes with him all these defects and blames, he "clears the board" for his successor and for the Council, the House of Delegates, and the committees. Therefore, let me assume any charges of the shortcomings that may have occurred in our organization. This I ask, not to be a martyr, but in sound principle, for our Society. Not one of us is indispensable. Therefore your retiring president can and should assume these charges for the good of our Society.

My predecessor passed the office of president to me in an untarnished state, and I expect to deliver it to my successor likewise.

Your president leaves his office with the satisfaction that he tried to improve the practice of medicine, to elevate the standards of medicine, and to benefit humanity through a longer, more useful, and happier life. It will be a delightful pleasure to become a member of that exclusive club — the Past Presidents of the Illinois State Medical Society.

H. Close Hesseltine

REPORT OF THE PRESIDENT ELECT

The report of the president elect will be very brief. The demands upon his time have been relatively small during the past year, due mostly to the active and efficient president and chairman of the Council. They assumed responsibility of attending most of the meetings where a representative of the Illinois State Medical Society was requested or advisable.

However, the president elect has attended all the meetings of the Executive Committee and the Council. He has also attended several committee meetings when requested and has been present at several of the district meetings where the new organization of the Illinois State Medical Society was discussed and explained.

He appreciates the respite from the strenuous activities of previous positions and expects to give a great deal more of his time and attention during the coming year.

Edwin S. Hamilton

REPORT OF THE FIRST VICE PRESIDENT

No report to be submitted.

REPORT OF THE SECOND VICE PRESIDENT

Since becoming an officer of the Illinois State Medical Society, I have attended all meetings of the Council and have marveled at the amount of important business transacted each time. The reorganization started about a year ago has already produced many tremendous as well as important changes in our Society and is gradually bringing us up-to-date in every way. We all appreciate these improvements and will more and more as we profit in the future from them.

I had the pleasure of representing our president at the open house of the fine, new hospital at Greenville and at the postgraduate program of the Bond County Medical Society in August, 1960. This was a large meeting and several members of the House of Delegates were present, together with a former resident of that community, Dr. Arkel M. Vaughn, past president of our Society, and a well known surgeon in Chicago.

At the request of Councilor Harlan English of the 8th District, I served as local chairman for the Councilor District meeting in Mattoon, on September 25. There I had the privilege of again representing our president and delivering his message to the group, in his unavoidable absence.

I attended the annual assembly of the Illinois Academy of General Practice at the Morrison Hotel in Chicago on Sept. 28, 1960, and presented greetings and best wishes from President H. Close Hesseltine, who had a previous commitment that evening.

As a vice president of your Society, who has fully enjoyed his nearly completed tour of duty, I desire to submit the following suggestions:

FIRST: That the Constitution and Bylaws be changed so that each vice president has the right to vote in the Council. This seems imperative to me in order that our voices may be heard at official meetings.

SECOND: That our Society provide automatic appointments for vice presidents such as the responsibility to work with some of the major committees of public relations, legislation, etc.

THIRD: In recent years many state societies have decided to send their officers, their

delegates, and their alternates to the American Medical Association meetings. I believe that the vice presidents should be included in this group to attend the AMA meetings with authorized expenses.

Perhaps I have exceeded my authority in making these suggestions, but I could not complete such a valuable year of service as your second vice president if I did not bring these thoughts for your early consideration.

I desire to thank President Hesseltine and all of the officers and other members of the Council who have increased my knowledge of organized medicine and helped me gain new friends in the Illinois State Medical Society.

C. D. Swickard

SECRETARY-TREASURER

As secretary-treasurer of the Illinois State Medical Society, I have had the opportunity during the past year to closely observe the development of the "new look" at the Chicago headquarters under the supervision of Mr. Robert L. Richards, the new executive administrator. Much of the work previously accomplished by the full time secretary-treasurer has now been included in the responsibilities of the executive administrator. I believe it apropos for me to comment that the progress which has been made in the past year has lived up to every expectation, and the cooperation which I have received from the staff of the Society is highly commendable. We have been in constant communication and liaison with respect to the dovetailing of our responsibilities, and my relationships have been most satisfactory with the office staff.

I can further assure the House of Delegates that we have a most competent staff. The developments in the past months have indicated a great potential for an efficient and smoothly operated Society headquarters in the future. As an officer of the state society, I recognize the significant contribution Mr. Richards and the other staff members have made in the short time that they have been with us.

During the past year, at the recommendation of the executive administrator, confirmed by the Council, there have been regional meetings in each of the councilor districts. These have been most helpful in bringing to the members the plans and activities of the Society, as well as a "listening post" for the staff to hear the needs and desires (as well as the complaints) of the membership. It is my feeling that these regional meetings should be continued — for at least another year — and their scheduling be well publicized to the members.

There are, however, many items of specific interest to secretaries and treasurers of county medical societies that have not been discussed this year. In an effort to effect a better unified and more efficient county-state liaison, a close working organization should be developed. Since new techniques for keeping records and new information forms on our membership are being considered, it is my recommendation that a secretaries-treasurers conference, including executive secretaries of county medical societies, be held during the forthcoming year and, if necessary, on an annual basis. In addition, consideration should be given to other items which can be of assistance to county officers, such as the development of a manual for secretaries and treasurers, adequate report forms, and general information regarding the business management of county medical societies. In discussing this with Mr. Richards, I find that he is in accord with this recommendation, and that the conference would not interfere with other planned activities for 1961-62.

It is well recognized that one of the long existing deficiencies of the Illinois State Medical Society has been a lack of adequate communication with its members. Difficult as it is to personally reach every member on a prompt time schedule, much thought and planning are currently being given to methods whereby this can be accomplished. It is hoped that within the current year, tangible proof of better communication will be noted by every member. One special phase of this endeavor is the development of a "Report to the Members," setting forth the major accomplishments during the year as well as anticipated future projects.

As secretary of the society, I have carefully reviewed the minutes of the 1960 annual meeting of the House of Delegates. These were edited and published in the August and Septemebr issues of the Journal. Copies of these minutes will be made available to each member of the 1961 House of Delegates.

Although it has been arranged to have a complete stenographic report of each session of the

1961 House of Delegates — and I believe this should always be done — it is my opinion that few members of the Society take the time to read such detailed minutes. I am, therefore, in agreement with the Journal Committee that the minutes of the House of Delegates should be abstracted for publication in the Journal. This will make it possible for each member of the Society to read immediately the important actions of the House. This is also one way to speed communications to the members.

It is also my recommendation that the verbatim transcript of the House of Delegates be made available to any member of the House of Delegates upon request to the executive administrator, or to the secretary. And it is further recommended that an appropriately edited copy of the 1961 minutes be made available for the 1962 meeting of the House of Delegates, and acted upon as the official minutes of the meeting. This should be carried out in succeeding years.

In my office as treasurer, I am able to report much progress and many significant changes since the 1960 annual meeting.

1. Effective May 1, 1960, the Council authorized the executive administrator to have the accounting system changed from a cash basis to an accrual system. The new auditing firm of Peat, Marwick, Mitchell & Company made the necessary adjustments and presented a preliminary statement on July 29, 1960. In order to make a smooth transition, there were many changes necessary; but in their letter of transmittal of the preliminary report, the auditors included the following statements which briefly explain the advantages of the accrual system:

> "On May 1, 1960, the Society changed its methods of accounting from the cash basis to the accrual basis. The change, which we approve, will enable the Society to prepare meaningful financial statements, for example:
> "1. The accrual method of accounting provides for a complete record of assets and liabilities to furnish readily at any specified date information as to the financial condition of the Society.
> "2. Income and expenses are allocated to proper accounting periods. In addition, budgetary controls are used more effectively when accounting records are maintained on an accrual basis."

2. Another important change recommended by the auditors, the executive administrator, and agreed to by the Council, and recommended by the Committee on Construction and Bylaws, was to change the Society's fiscal year from May 1 through April 31 to a calendar year from January 1 through December 31. This recommendation was made because the dues of the Society are collected on a calendar basis. In anticipation that the House of Delegates would approve this recommendation, the executive administrator was requested to draft a budget beginning with Jan. 1, 1961, and ending Dec. 31, 1961. As promised to the House of Delegates at the 1960 meeting, the budget as approved by the Council will be made available to the 1961 House of Delegates. It will also be made available to any other member of the Society upon request to the secretary-treasurer. This, in addition to the auditor's report covering the eight-month period from May 1, 1960, to Dec. 31, 1960, will be mailed to each member of the House of Delegates on or about April 15, 1961. Members of the Finance Committee, the auditor, the executive administrator, and the treasurer will be available at the reference committee hearing to answer any questions which members may have on the details of both the audit and the budget.

3. At the time of preparing this report, the executive administrator has been authorized by the Council to make certain changes in the fiscal internal control program which will assure more adequate safeguards for the funds of the Society. You may be quite certain that all efforts possible have been made, and will continue to be exerted to maintain these controls consistent with the highest standards of accounting procedures as recommended by our auditor.

4. It is important that the House of Delegates understand the present fiscal position of the Society, and what has been the effect of the staff reorganization on our reserves. At the time of the last annual meeting it was predicted that by the time dues were collected for 1961 there would be few, if any, reserves. Anticipated deficits, based upon the dues income for 1960, were fortunately overestimated. Furthermore, good management practices in gradually filling staff positions of importance over the period of the last eight months resulted in a reserve of $151,000 as of Jan. 1, 1961. This included $93,000

in government bonds, and the remainder has been placed in a savings account.

Generally speaking, it is a rule of thumb that any organization should have reserves adequate to operate on for six or twelve months. With anticipated monthly expenditures during 1961 to be approximately $50,000, our present reserves appear to be less than adequate. It is expected, however, that from the current budget will be accrued a minimum of $10,000 additional reserves. Thus it is planned that reserves will be increased each year until they are adequate.

Although it may be commented upon by the chairman of the Council, it would seem to be appropriate for the treasurer to mention that the program of implementing the Kerr-Mills Bill in Illinois, in addition to the public education and public relations aspects, may cost a sum which was not fully anticipated in the 1961 budget. This, and other items which have been given first priority by the Council insofar as staff activities and budgets are concerned, may quickly utilize any excess of income over anticipated expenditures for 1961, and even make it necessary to use some of the present reserves. Obviously, it is hoped that this will not occur, but I think the House of Delegates should be prepared for contingencies in these areas which are most difficult to fully anticipate.

One final action, which has been approved by the Council and which is made much easier with the accrual accounting system, is the investment of current dues income in savings accounts and government bonds. All funds, with the exception of approximately 45 days' operating costs, are on deposit in savings. When interest rates improve, some of our funds may be placed in short-term government notes. Inasmuch as the AMEF contribution is a portion assigned from each member's dues, it is planned that this money will also be placed in savings until the end of 1961, and then transferred to the AMEF. In this manner, the Society will benefit by securing the accumulated interest on approximately $180,000.

MEMBERSHIP STATISTICS

Members as reported May 1, 1960		10,253
New members	137	
Reinstatements	143	
Total added		280
		10,533
Dropped during the year:		
Died	139	
Moved from state	24	
Resigned	2	
Expelled	0	
Nonpayment of dues	199	
Miscellaneous	1	
Total dropped		365
Membership as of Jan. 1, 1961		10,168

Jacob E. Reisch

REPORT OF THE EXECUTIVE ADMINISTRATOR

The events of the last eight months have greatly challenged my capabilities to assume the responsibilities of Executive Administrator of the Illinois State Medical Society. The record is clear on my prior experience in the field of organized medicine, and need not be repeated. However, I can truly say that this position has been the most challenging which I have ever faced.

To relate the development and the reorganization of our staff as of the time this report is being prepared would require someone much more eloquent than I. We of the staff must stand on our record. Suffice to say, results must speak for themselves in the many areas and facets of activity of the Society. The reports of your officers and committees will, in part, speak for the effectiveness of the staff. More than this, however, the hundreds of physicians who have attended regional meetings and county medical society meetings, where staff have appeared, will perhaps attest to the usefulness of our staff in accomplishing the purposes of the Illinois State Medical Society.

Objectives

Some members of the Society will undoubtedly tell us that we have done an acceptable job. Certainly we who are on the staff feel that we have succeeded in accomplishing the immediate objectives, which I outlined in May, 1960, before the House of Delegates. Stated briefly these were: (1) to plan a reorganization of staff which could adequately serve the needs of a modern state medical society; (2) to employ and, where needed, to train the staff and integrate their various responsibilities so that no area of possible service to members could be overlooked, and (3) to have staff directors visit in each councilor

district to introduce themselves to the members and to seeure the understanding and partieipation by members in the Society program. A key question before us, however, is what do you as members of the House of Delegates—or perhaps more important—what do the 10,000 members of the Illinois State Medical Society think of our aceomplishments thus far? Have we communicated our purposes and our objeetives to you and to the other members of the profession? In this respeet, an expression of opinion from the reference eommittee and the House of Delegates may be helpful in planning our future activities and programs.

Staff Reorganization

At the time I reported for duty on June 21, 1960, there were eight full-time employees remaining from the previous ten full-time employees. There were six part-time employees remaining. We now have 26 full-time employees, and four part-time employees. They were eare-fully selected. They are being trained to meet the needs of the Illinois State Medical Soeiety. They know their specifie responsibilities and are working hard in your interest. Their number eompares favorably with the number employed by California, which is 43 full-time employees and four part-time employees. Pennsylvania employs 36 full-time employees, and three part-time employees. New York employs 72 full-time employees, and four part-time employees.

On March 13 the last member of the staff reported for duty to complete the ehart of organization as presented to the House of Delegates in May 1960 and published in the August 1960 Journal. An up-to-date chart is submitted as Appendix I with this report. Each position has been fully explained in a position deseription whieh includes both responsibilities and authority inherent in eaeh. It is my hope that no other employees will be neeessary, that we will be able to provide the services I have explained in reports to the Council with the present staff.

I have promised the Council that the budget will be a maximum budget. It is our pledge to be guided by the need to receive the most and the best for eaeh dollar that is spent. I should like to add, however, that it is entirely up to the Counеil and the House of Delegates to decide whether inereased services from the state medical society will be necessary. It is my considered opinion that the present staff is adequate. We are well able to provide the usual serviees provided by large state medical societies in other parts of the country. We have a well qualified staff and employees who enjoy working for the love of serving. In my own evaluation of the the serviees of the three larger state soeieties, I sincerely believe that our organization and its staff is equal to and superior in most respeets to those of New York, California, and Pennsylvania.

After we have eompleted the first year of serviee—the shakedown cruise so to speak—it is my intention to use the serviees of a management consultant to objectively evaluate our techniques and the effieiency of our operation. I eonsider it my continuous responsibility to provide the most effieient service possible with the funds and staff available. To this end I pledge my undivided attention.

Recommendations of Management Survey of 1959

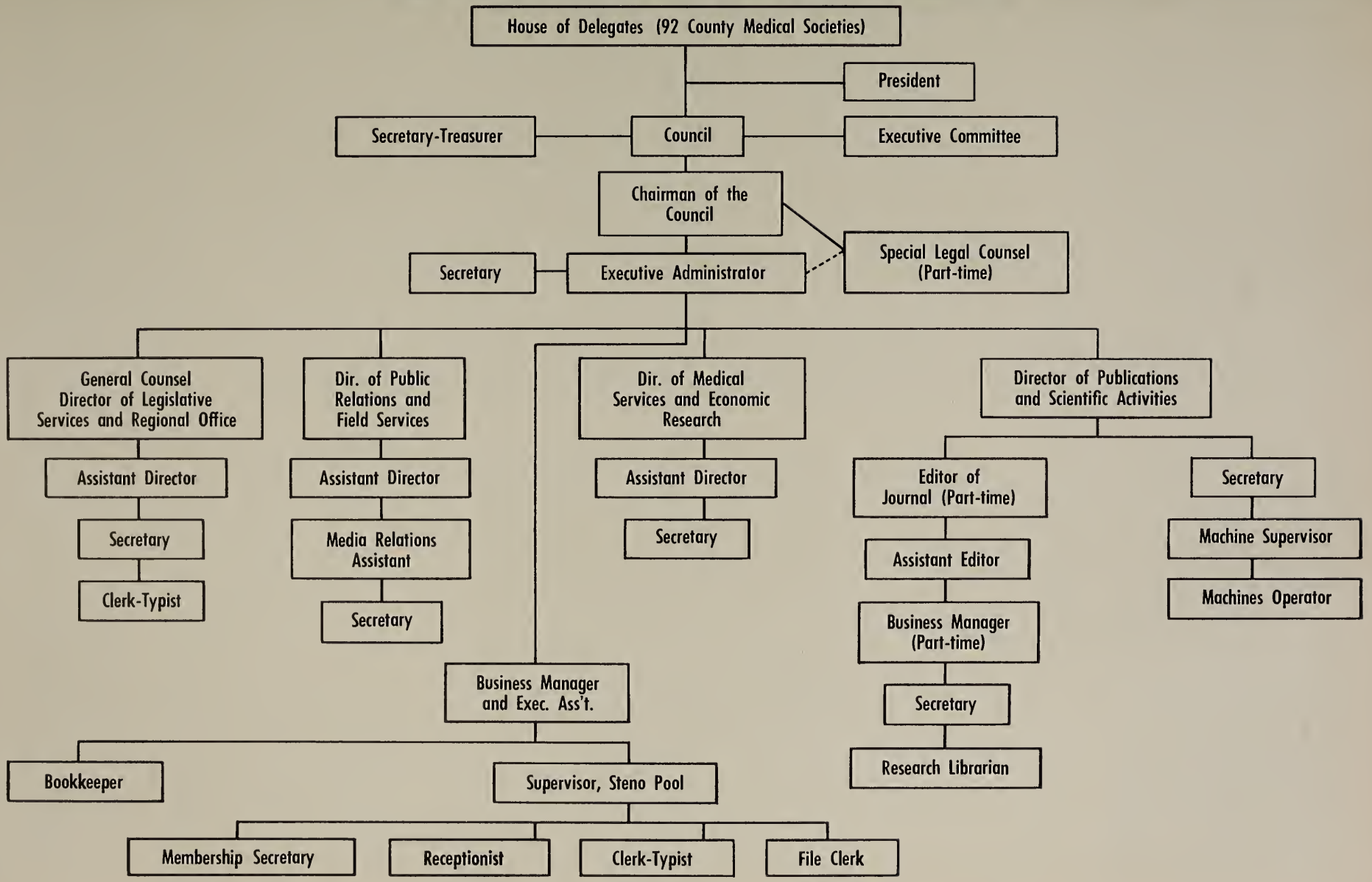
I have made a review of the reeommendations and the actions of the House of Delegates on eaeh one. I am pleased to report that most approved reeommendations have been implemented. The few that remain are either being considered by the proper eommittees of the Soeiety or have not been implemented because the full year of aetivities has not been completed.

Those reeommendations pertaining to plans for the Annual Meeting, ineluding the meetings of the House of Delegates and the scientifie sessions, have all been given close attention. We hope that the House of Delegates will be pleased with the newly instituted changes.

The management of a state medical society is in many ways similar to that of the management of any business. Budgeting, employment of staff, preparation and explanation of personnel policies, the proper delegation of responsibilities, individual service to members, and services to groups of members as represented by eounty medical societies are all important funetions.

The myriad details of the reoganization of the Society need not be expounded in this report. Most of these have been diseussed in meetings with the Finance Committee and the Executive Committee and before the Council. Any questions the House of Delegates may have with respect to our services and staff polieies will be answered with dispatch. I do commend to you the aetivities of our present staff and the work whieh they

CHART OF STAFF ORGANIZATION ILLINOIS STATE MEDICAL SOCIETY As of March 1, 1961



have provided for you during the past six months. I have complete confidence in our ability to deliver whatever you may request, as long as it is consistent with the policies of the House of Delegates, and within the finances of the organization. There have been no such words in the past six months as "we cannot do it." The question has simply been "How soon can we get it accomplished?"

We would like to take this opportunity to express the sincere appreciation of all our employees to the members of all the committees, to the Council, to the officers, and to the many representatives of the profession whom we have met in our field contacts. I assure you that our staff is available for service to you and to the members of your county medical societies.

Robert L. Richards

REPORTS OF DISTRICT COUNCILORS

First District

The First Councilor District of the Illinois State Medical Society, occupying the northern ten counties west of Cook County, have presented no problems beyond those which they have solved for themselves. No particular action by the House of Delegates seems to necessarily apply to these organizations. In some instances the societies are properly preparing resolutions to be presented at the annual meeting. This implies House and reference committee action.

In October, 1960, a very successful district meeting was attended by multiple representatives from all but one of the county societies. At this meeting the newly appointed personnel and purposes of the state society were presented. It was a very fruitful meeting in that information was received by the members to take back to their societies. Proof that it was a good and productive meeting is evidenced when these societies have been observed in action.

All of the societies, especially the larger ones, have a group of members who are dedicated to the cause of organized medicine. Another group is lackadaisical. It is this group of members that must be developed as working members and convinced that unless they are willing to contribute something to their Society, they will get nothing out of it. For medicine to survive as a body, this must be changed and can only be brought about by members themselves. The First District is no different from others in this problem.

Carl E. Clark

Second District

The past year has seen an interesting and progressive phase in the reorganization of the Illinois State Medical Society. This reorganization was presented to the county medical societies of the Second Councilor District by an expanded and balanced headquarters' staff at a meeting in La Salle in October, 1960. I am pleased to report that all of the county societies were represented at the meeting, and a very interesting and stimulating discussion followed the reports by the departmental heads.

The county societies have held their scheduled scientific meetings, and interesting programs have been presented by well qualified men from Chicago, Peoria, and Rockford. There has also been a heartening increase in the interest of social welfare and medical politics by members of the Second District. The district was represented by the medical profession at the January White House Conference on Aging, Washington, D.C.

Your councilor presented a Fifty Year Club Certificate to a member of the Livingston County Medical Society, Dr. William A. Marshall of Fairbury.

There have been combined meetings of county medical societies and county bar associations. These meetings are to be commended; not only do they create better understanding between the two professions, but they also help to bring closer the time when impartial medical testimony will be generally accepted.

There has been concern voiced about the policy of the IPAC in requiring prescriptions for certain drugs rather than allowing the local physician to dispense these in localities where there is no pharmacy. It has also been felt that the IPAC should do away with the differences in charges made for drugs as now set up for the pharmacist and physician.

Your councilor is an alternate member of the Maternal Welfare Committee, a member of the

Committee on the Constitution and Bylaws, a member of the Committee on Medical Service, and a member of the Executive Committee of IMPAC.

Your councilor wishes to thank the officers and members of the county medical societies for the courtesies and hospitality extended to him. It has been a pleasure to work with the officers and councilors of the Illinois State Medical Society and with the members of the headquarters staff. Their help and cooperation has been greatly appreciated.

Ralph N. Redmond

Third District

The Chicago Medical Society, mindful of its responsibilities and its obligations to the profession and to the public, continues to develop new activities and to extend its regular program. Every effort is made to bring the newest developments in medical science to the physicians in Cook County and to promote good health for the people in this area.

Clinical Conference Committee

The Chicago Medical Society presented its seventeenth Clinical Conference, February 28, March 1, 2, and 3, 1961, at the Palmer House.

A faculty of 31 outstanding teachers presented scientific papers covering all phases of medicine. In addition, there were color motion films and live color telecasts from the University of Chicago School of Medicine and Billings Hospital daily. Four instruction courses each day provided the registrants with an interesting educational experience. A program on trauma presented by the Chicago Committee on Trauma of the American College of Surgeons was held on March 1 and proved to be a most interesting session. The scientific exhibits were well received and three awards were presented.

Attendance at the conference was very gratifying.

Doctor's Emergency Service

The Doctor's Emergency Service of the Chicago Medical Society continues to render an important service to any patient who is ill, who has no physician, or is unable to reach his own physician. This service operates night and day during the entire year. During the year of 1960, 13,000 patients were treated in Chicago and Cook County. This does not take into consideration the thousands of return professional calls made on these patients. This service also offers the public an opportunity to choose its family physician from the panel of 265 doctors. All records of calls made by the physician with the diagnosis and treatment of the patients are kept on record at the office of the Chicago Medical Society, 86 E. Randolph Street.

Ethical Relations Committee

The Ethical Relations Committee is pleased to report that very few cases have been referred to it during the past year. Much of the work has been answering inquiries regarding ethical practice.

Grievance Committee

The Grievance Committee handled 336 complaints during the year 1960; total number of doctors written to was 420. Most of the complaints were due to misunderstanding or related to doctors' fees and were settled without the necessity of calling in the doctor and complainant. In some cases the committee recommended an adjustment in fees and a friendly settlement was reached. Twelve doctors were called in, and seven complainants and their cases were settled satisfactorily. A few cases required additional investigation. Ten doctors were reprimanded for not being cooperative with the committee; 19 complaints received were from obviously psychotic people. Two cases were referred to the Committee to Investigate and Consider Informal Charges of Unethical Conduct for examination.

The committee has been increased to nine members; they should be commended for the fine work they do in trying to settle these complaints. A small portion of the number of complaints received represents justifiable grievances against physicians.

May we take this opportunity to remind the members of the Illinois State Medical Society that in the practice of medicine public relations is taking on an increasing importance. We wholeheartedly suggest to our membership the necessity of adequately explaining procedures and fees to patients and families prior to rendering service to them whenever it is possible to do so.

Committee to Investigate and Consider Informal Charges of Unethical Conduct

This committee acts as a fact-finding body for the Council of the Chicago Medical Society. Physicians charged with violation of ethics are heard informally before this group. If charges are found unwarranted, recommendations that no further action be taken are brought to the Council. If charges of misconduct are substantiated upon evaluation of the evidence, recommendations are made to the Council that the physician be charged formally with unethical conduct and that he be summoned before the Ethical Relations Committee.

In most instances, problems have been adequately mediated at the committee level. Twelve complaints were handled during the past year. Disciplinary action, ultimately resulting in the suspension of the member by the Council, occurred only once.

Polio Immunization Committee

The Chicago Medical Society Committee on Polio Immunization, in anticipation of a high-cycle year in 1960, recommended early through the newspapers the importance of polio immunization. Since it was not known how many doses of polio vaccines are necessary to produce 100 per cent protection, it was recommended that a booster dose be given yearly until such time that scientific research evaluation will have the answer as to the certainty of complete immunization.

Postgraduate Courses

The two postgraduate courses, one in Modern Therapeutics and the other in Modern Diagnostics, were held at the Knickerbocker Hotel during the latter part of October and the first week in November, 1960. Both courses were well attended by physicians from all over the country and also Canada. A good number of Chicago physicians were also in attendance.

These postgraduate courses which are held each fall under the supervision of the Chicago Medical Society are always very popular with the practicing physician. The lectures were presented by outstanding and well recognized physicians.

A course in Obstetrics and Gynecology and one in General Surgery will be given this fall at the La Salle Hotel.

Committee on Professional Orientation

This is the third year the Committee on Professional Orientation has been meeting with new or transfer members to discuss the privileges, benefits, and duties of membership in the Chicago Medical Society. All the members of the committee have been active in the sessions, as well as the officers of the society and the president of the Illinois State Medical Society, Dr. H. Close Hesseltine.

Forty to eighty new members are in attendance at the tri-monthly meetings which have been considered highly successful in making them feel welcome and in stimulating their interest in active participation in the affairs of their local branches and hospitals.

Membership in the society is not held up pending their attendance; therefore, we have a small backlog of new members who have not attended an orientation meeting. Continued efforts will be made to assure their participation.

Public Relations

In addition to the over-all public relations of the Illinois State Medical Society, attention is given to this matter in the Third Councillor District by many different committees. During the past year a joint effort was made through the help of TV station CBS to bring the realities of medicine home to the public by means of the one-half hour program entitled "The Four Seasons." This presentation showed a successive group of physicians extending their care and services through four growth periods of life, i.e., childhood, youth, and middle and old age, together with an interview portrayal solving a problem of mental health.

Chicago's Home Care program was studied through participation with a committee of the Welfare Council of Metropolitan Chicago. At present such a plan is operative through three Chicago hospitals, Michael Reese, Mount Sinai, and Mercy hospitals. This activity is designed to extend the hospital care of the medically indigent from the clinic into the home. It is a team approach, well designed to emphasize rehabilitation where such is possible. The team consists of physician, nurse, physiatrist, and social consultant. While such service in the home makes continued care of the patient possible, it also makes possible the use of more hospital beds for those acutely ill.

Committee on Tuberculosis Control

The incidence of new tuberculosis cases and the incidence of mortality from pulmonary tuberculosis continues to decline. The decline is not as marked as in previous years but it continues. The case-finding program continues to be intensified and is now being carried into those areas with a known high incidence of tuberculosis.

Woman's Auxiliary Activities

This year the work of the Woman's Auxiliary to the Chicago Medical Society has been most interesting, and we feel they have accomplished a great deal.

The Society's auxiliary members have given every assistance possible to the Chicago Medical Society in carrying out their legislative program.

The various events of the Woman's Auxiliary have been well attended. The speaker, Salom Ryzk, for the Community Service Day program spoke on the subject, "America is More Than a Country." Generous contributions from the auxiliary to our medical and charitable funds showed member-cooperation in such projects as the American Medical Education Foundation, Benevolence Fund, and Recruitment.

Our year has been successful due to the hard work of the board, directors, and chairmen, not only of Cook County but all of the twelve branch societies.

We sincerely hope that what we have built on the foundation given us this year will continue to rise to greater heights for those who succeed us.

William E. Adams
John L. Reichert
Caesar Portes
Edward A. Piszczek
J. Ernest Breed
Ted LeBoy

Fourth District

The constituent societies of the Fourth Councilor District have had few problems during the past year.

The first meeting of the district delegates and society members was held in Peoria at the Pere Marquette Hotel Sept. 18, 1960. This was the first such district meeting attended by our president, H. Close Hesseltine, and the new members of the headquarters staff. It was well attended and familiarized those present with the new objectives of the Society and the staff.

There have been no postgraduate conferences held in this district during the past year.

At the time this report is being written, all component county societies have not been visited, but will be visited before the annual meeting.

A Fifty Year Club pin and emblem were presented to Dr. Harrison C. Putman of Canton (Fulton County) on Jan. 12, 1961.

All of the Council meetings, with the exception of one, were attended by your councilor.

Fred C. Endres

Fifth District

The Fifth Councilor District is fortunate in having component societies which are active, progressive, and well organized. The leadership and capabilities of the officers and committee chairmen of the various societies is evident in the success of the projects sponsored and effectively completed. It would appear to the councilor of this district that the membership in general is more aware and disturbed by the problems currently facing medicine than in the past, and is more anxious to preserve our heritage.

Specifically, several activities in the district merit notation. Both Tazewell and McLean counties have continued their annual joint meetings with the members of the legal profession, and these meetings have brought closer liaison resulting in mutual benefits. This should be encouraged in other societies.

Tazewell County honored one of its outstanding members, Dr. Robert E. Dunlevy, at a testimonial dinner on Nov. 3, 1960. This meeting was one combined with the Peoria County Medical Society, and to it were invited members of the press and several other guests. In addition to numerous laudations, including one from the president of the state medical society, Dr. H. Close Hesseltine, who was the evening speaker, Dr. Dunlevy was presented a plaque attesting to his long continued devotion and services to the Tazewell County Medical Society. Part of its inscription read, "This award is made in recognition of the tireless efforts which Doctor Dunlevy spent on behalf of organized medicine in our county during the past ten years."

A somewhat different version of a Postgraduate Conference was held by the Logan County Medical Society at Lincoln on March 16. Termed a "Naborhood Meeting," its scientific speakers for the afternoon program were from Decatur, Peoria, and Springfield. The evening program provided a pleasant variance from diagnosis and therapy — "The Morbidity and Mortality of the Lincoln Children" and "Civil War Medicine" were well listened to by both the physicians and their wives.

In Springfield numerous meetings and conferences have taken place during the year, and these will increase in number as the legislative year progresses.

As usual, the Society had an exhibit at the Illinois State Fair in August. This display, selling nothing but medical education and suggestions on health care, is enjoying a larger attendance each year and can be considered an effective public relations venture.

At the time of the early preparation of this report, two major functions are scheduled for Springfield — the biennial Legislators' Dinner to be held on April 18, and a Fifth Councilor District Regional Conference on state office activities scheduled for April 6. To this meeting is to be added for the evening program a discussion on the Relative Value Scale which will be presented by the Committee on Medical Economics.

In review of my activities for the Illinois State Medical Society during the past year, I have served as secretary-treasurer; attended the annual and clinical meetings of the AMA as alternate delegate; attended all meetings of the Council and served on the following committees: Executive Committee; Finance Committee; Committee on Medical Service; Illinois Division, American Legion Liaison Committee, chairman; and the Medical Editorial Board. I have been chairman of the Journal Committee, Committee on Narcotics and Hazardous Substances, Committee on Springfield Office Location, and the Governor's Necropsy Board.

To the many members of the profession and to the officers of the component societies of this district, I express my appreciation of their cooperation and help during the past year. It is indeed an unusual privilege to have enjoyed the friendship and fellowship of so many.

Jacob E. Reisch

Sixth District

The affairs of the Sixth Councilor District are in good order, thanks to the officers of the county medical societies and those members who are actively interested in serving the Illinois State Medical Society. There is enthusiasm throughout our district for the new regime directing the activities of our state medical society. In Jacksonville on Nov. 13, 1960, representatives from the county societies met our administrator and the new staff directors to hear plans and policies outlined. This was an excellent meeting and, in my opinion, should be repeated at yearly intervals. The auxiliaries of this district were also represented at this meeting. Our administrator and the staff directors should be commended for their concise presentations.

The Fifty Year Club has a new member. A certificate was presented to Dr. Roy C. Barry of Lebanon at Madison County's annual meeting with its auxiliary.

One of the societies in this district is sponsoring a student academic achievement program which, after being approved by the Illinois State Medical Society, has attained national recognition. Recently it has been endorsed by the American Medical Association as well as by Kiwanis International.

Your councilor has attended all of the meetings of the Council and serves as chairman of the Liaison Committee to the Illinois Bar Association, and is a member of the Committee on Impartial Medical Testimony, Committee on Nursing, Liaison Committee to the Illinois Hospital Association, and the Finance Committee.

To the officers and members of the county societies, I am most grateful for the honor of being re-elected councilor. I am very appreciative, too, of the many courtesies and hospitalities extended on the occasion of meetings with the various county societies in the district. My sincere thanks are also extended to the officers, the administrator, and the staff directors of the Illinois State Medical Society.

Newton DuPuy

Seventh District

The constituent societies of the Seventh District have had no major problems during the past year, and to date there have been no meetings

required of the district's committees on ethical relations, grievance, or prepayment plans and organizations.

Your councilor's time has been filled with many duties. He has attended all meetings of the Council during the past year. He has also served as a member of the Constitution and Bylaws Committee, the Illinois Bar Association Liaison Committee, the Impartial Medical Testimony Committee, the Committe on Nursing, the Permanent Home Committee, and is at present Chairman of the Ad Hoc Committee on the "Over 65" Problem.

The contact with county societies has been made mostly through the presentation of Fifty Year Club Certificate and pin awards. Informative material relative to the actions of the Council and the society has been imparted on these occasions.

Fifty Year Club Certificate and pin awards provide excellent public relations not only from the standpoint of the profession but the public as well. Awards were presented to Ernest M. Montgomery, M.D., of Shelbyville, and James M. Sparling, M.D., of Moweaqua at a special meeting of the Shelby County Medical Society at the Shelbyville Country Club on May 2, 1960. In Centralia on May 4, 1960, at a special combined meeting of the Marion County and Jefferson-Hamilton County medical societies Gov. William Stratton was visibly impressed and gave a very excellent talk to the Fifty Year Candidates and the audience. Dr. Andy Hall, president of the Fifty Year Club, presented his nephew, J. Carl Hall, M.D., of Centralia, his certificate and pin. He also presented a certificate and pin to Dr. William Parker of Mt. Vernon. Dr. H. D. Gillette's certificate and pin were presented by your Councilor. At White Heath, W. N. Sievers, M.D., was presented his certificate and pin on August 26, 1960. He was bedridden at the time and greatly appreciated his awards. Dr. Sievers served as delegate from the Piatt County Medical Society to the House of Delegates for 39 years. I regret to state he died one month later.

Lee O. Frech, M.D., formerly of Decatur, who retired from practice one year ago, was awarded his Fifty Year Club Certificate and pin in San Diego, Calif., at a meeting of the San Diego County Medical Society on Jan. 10, 1961. Paul Foster, M.D., prsident of the California State Medical Association, made the presentation. It was felt that the cooperation on the part of the San Diego Medical Society as well as the president of the California State Medical Association represented the finest of interrelationship and courtesy between state medical societies.

Only one postgraduate conference was held in the district during the year. This was a special conference at which the staff of the Jewish Hospital of St. Louis, Mo., presented an excellent program at the opening of the new Greenville Community Hospital. The program was developed and sponsored by the Bond County Medical Society. There was an excellent attendance by physicians from central and southern Illinois.

The women's auxiliaries have been very active, and your councilor greatly appreciates their work.

I wish to express my gratitude also to the officers and members of the medical societies of the Seventh District for their cooperation and help during the past year.

Arthur F. Goodyear

Eighth District

The day-to-day medical affairs in the Eighth District appear to have gone off well during the last year. A district-wide meeting for all the officers and delegates was held in Mattoon in the fall of 1960. Sixty to eighty persons attended, and I sincerely believe profited by their acquaintanceship with our management team. My personal opinion is that our district will want to meet with the management team about every second or third year.

Spring will bring our usual postgraduate conferences. Only time will tell the interest exhibited toward these, and the benefits derived therefrom.

The acute hospital-bed problem in the district appears to be under good control. Sufficient beds are available when honestly needed for acute cases. Further building for more such hospital beds in the district is probably open to serious question. With the new administration taking over in Springfield, it is hoped that the state health department will use the advice of informed people in the field of hospital planning and that the recommendations of the Illinois Hospital Association to the state department of health will receive early attention and implementation lest the errors of the past be com-

pounded in the future. Planning mistakes are to the detriment of the intelligent use of such health facilities as are now available or can be intelligently planned for our state.

Our district, like most other areas in the state, has not been able to recruit its most intelligent young people in the field of medicine. This probably is the greatest tragedy facing our country, and the activity of the new administration in Washington will do little to induce students of top level ability to take up medicine as a life's work.

Our district grievance committee will hold its first meeting early in January. With more and more people becoming more "suit conscious" I suppose we can look forward to nothing but suits and more suits. Should the grievance committee mechanism hold these to an irreducible low, it is my opinion that the public and medicine will have gained.

Harlan English

Ninth District

Apparently the Ninth Councilor District has gone along without too much difficulty during the past year. There have been no problems referred to our local or district grievance committees and no problems were communicated directly to me.

At the present time we have several members of this district who are serving well and faithfully on some of the major committees of the Illinois State Medical Society. I feel that they should be congratulated for this because of the time and effort involved in such work.

The district meeting of the Ninth Councilor District is to be held on March 30, and members of the various county societies in the District will be invited to attend. We hope that there will be a rather large attendance since this is the time we get acquainted with our staff.

It is evident to your councilor that the new administration in the Illinois State Medical Society is doing an outstanding job, insofar as working for the profession is concerned. All departments are functioning well, and I feel that it will be only a short time until the results of these activities will be felt at the grass roots in each county medical society area.

I would appreciate very much having the names of members of the county medical societies in the Ninth District who would be willing to serve on committees of the state medical society. They should be transmitted to me at or before the time of our annual meeting in May in Chicago.

I wish to extend my sincere thanks to all the members in the Ninth District, and to the officers and councilors of the Society for their wonderful cooperation during this year. I also wish to extend my appreciation to the new staff of our Society for their wonderful cooperation and kindness during their very busy period of becoming acclimated to the new regime of our state society.

B. E. Montgomery

Tenth District

I wish to take this opportunity to thank the officers, particularly the presidents and the secretaries, of the various county societies of the Tenth District for their efficient attention to their duties during the past year.

We have witnessed many historical turns of events in this period of time since we last met, which would indicate that our path ahead is not apt to be one of roses.

We have seen our neighbors to the south practically condemn us as aggressors.

We are witnessing and experiencing a political change in our own country, the foreboding of which may involve us all directly. There is no doubt that if the socialistic planners of our nation manage to get through the legislation they have been pressing for for years, we will all feel the impact of their design, not only on ourselves but more particularly on our patients as they become a part of regimented care. Therefore, it behooves us to think clearly to master the situation as best we can. We are all in the profession of medicine because we chose it and because we feel we have a certain obligation to humanity. We must never lose sight of our ideals. We must continue to fight for our free enterprise system and at the same time not forget our obligation to our patients and to ourselves.

You are all aware of the fact that the society has gone through a reorganizational phase during the past year. We have our Executive Administrator Robert Richards and his three new associates—Don Martin, Roger White, and Al Boeck and our good friend and helper, Mrs.

Frances Zimmer, who has been with us for many years and knows more about Illinois doctors than anyone else in the organization. Mrs. Zimmer is now employed as the executive assistant. Also, a time-tested and loyal friend is the director of the Springfield office, Walter Oblinger.

It is presumed that by the time of this meeting of the House of Delegates that the office staff will have conducted district meetings throughout the state.

The meeting for the Tenth District was held Sunday, Oct. 2, 1960; eight of the nine counties were represented. The attendance was thirty-six. These people came to sit in a closed room on a beautiful Southern Illinois Sunday afternoon, as the Society representatives began their attempt to bring the state organization down to the grass roots level. Undoubtedly, we will have more of these meetings in the future, the character of which, of course, will have to be worked out. However, within our professional organization we hope to have a more intimate and closer relationship between the state level of our organization and the grass roots level for the medical men in Illinois.

Again, I thank all of the officials of the county medical societies and the delegates for their splendid cooperation in the past year.

Willard W. Fullerton

Eleventh District

Your councilor has concerned himself, along with the other members of the Council, in dealing with the challenging problems of the Society during the past year.

One of the most pressing of these issues was the new plan for the reorganization of the Illinois State Medical Society. This was resolved by the selection of Robert L. Richards as the new administrator and the appointment of other new members of the staff.

In line with these new developments it was suggested that district councilor meetings be held for the purpose of general orientation of the membership and of discussion of ways the Society could be more helpful to county medical societies.

Accordingly, the first such meeting of the 11th Councilor District was held in Joliet on Oct. 30, 1960. All but one of the component medical societies was represented. The members of the Will-Grundy County Medical Auxiliary graciously assisted in registering the guests. Mrs. Charles Wunsch, president of the state Woman's Auxiliary, was also present and made pertinent remarks during the session.

The program consisted of panel presentations by the various members of the new staff. All in all, it was an excellent meeting, with lively discussions entered into by a number of those present. Everyone agreed that the district meeting served a useful purpose and expressed a desire to have it annually. In the evening Dr. H. Close Hesseltine, president of the Illinois State Medical Society, gave an inspiring address.

The component medical societies of this district have been active and very cooperative in all the programs initiated. There have been no serious problems requiring the attention of the district Ethical Relations, Grievance, or Prepayment Plans and Organizations committees.

Your councilor had the pleasure of awarding Fifty Year Certificates to Dr. Orvan A. Phipps and Dr. James W. Turner at a meeting of the Kankakee County Medical Society.

Your councilor attended all the Council meetings and takes this opportunity to thank the component medical societies of this district, the members of the Council and the new staff for their friendly cooperation.

Bernard Klein

Councilor-At-Large

Your councilor-at-large has had a most happy year and has been quite busy with various assignments, up until the present time when he has been laid up with an acute hepatitis, which temporarily put him "on the shelf." He hopes, however, to get back to his duties.

After the two active years as president elect, and president of the Illinois State Medical Society, it is extremely relaxing to be able to sit back temporarily, and see the administrative lot of those two offices fall on such capable shoulders as those of Dr. H. Close Hesseltine. Your councilor-at-large has noticed in the past that many leaving the active position of the state president have felt rather left out of things, that they had very little to do except sit on the side lines. Fortunately, your present councilor has been given some very pleasant assignments, and enjoyed more activity as the year progressed. He

has been chairman of a committee, appointed by the president, to look into the matter of a permanent home for the Illinois State Medical Society. He has been chairman of the committee to look into the matter of postgraduate education in the state. Both of these assignments have proved very interesting. Neither of them has been too arduous, but they have kept well-stimulated the interest of the past president. I leave the Council this year, after thirteen years of active interest in the affairs of that body, and of the state, after having had the pleasurable experience of being chairman of the Council for two years; then being president elect, and following that, the president of the Illinois State Medical Society. I have many fond memories to dwell on over the allotted time left to me. The trust of the Illinois State Medical Society, of the House of Delegates, and of the Council have been much appreciated by me. The old fellowships, which have cemented more closely, and new acquaintances, which I have made in these offices, the opportunity to represent you on many occasions to lay organizations have been most interesting, and my hope is that they have been carried out to your satisfaction.

What heritage could I leave to such an excellent and cooperative an organization. Not much, I'm afraid, but a request that you keep going ever forward; that you militantly make your presence felt in the material things which are best for the people of Illinois; that you be constantly aware of the "snipers" along your path because Illinois medicine, and American medicine as a whole, is at such a crossroads—and will be so during these coming two years—that you must be constantly aware of this, that you fight the inroads of being constantly tempted by people who do not understand us and do not care to understand us; that you enlist the support of your communities, alerting them to the dangers which exist between the wonderful doctor-patient relationship which they have, I am sure, enjoyed, but which many of them have taken for granted. You have heard this sort of philosophy before, many times, but I think repetition is good for us all.

Again, I want you to know I am deeply appreciative of the honors bestowed upon me. I do not intend to sit back and watch things from the side line, and I hope my voice will still be heard as a member of the House of Delegates for years to come. I shall do everything I can to help.

Joseph T. O'Neill

ILLINOIS DELEGATES TO AMA

Reports of both meetings of the AMA House of Delegates have been published, but a few highlights deserve reiteration.

A recommendation from joint action of the AMA and the American Hospital Association, in consultation with the State Department, granted extension of time to those graduates of foreign medical schools, provided (1) they were enrolled in a suitable educational program, and (2) provided they are accepted for the April, 1961 examination by the Educational Council for Foreign Medical Graduates.

The House of Delegates approved a scholarship and a loan program for medical students. This program will require an increase in AMA dues, temporarily approved as $10 in 1962 and $10 in 1963. This means that AMA dues in 1962 will be $35 and in 1963, $45.

In the health insurance field, the House approved a cooperative venture with Blue Shield, the American Hospital Association, and Blue Cross in the development of the voluntary, nonprofit prepayment concept to provide health care for the American people. Also approved was coordination of efforts with the private carriers.

In the field of health care for the aged, the House reaffirmed the association's support of the Kerr-Mills Bill, and recommended continued opposition to the use of the social security mechanism in providing medical aid to the elderly.

The House also asked the Board of Trustees to study the question of blood replacement responsibility and the matter of establishing health insurance fee schedules for surgical assistants.

The Board of Trustees also was asked to make an effort to reduce the number of physicians who are nondues-paying; also to present a program of retirement and disability insurance.

In June the House referred to the Board for decision the question of whether fund raising agencies should be studied so that the public may be advised about their monetary efficiency.

The House rejected a recommendation to specify two-year internships; approved a proposal for an efficiency study of hospital records; continued opposed to the inclusion of physicians under the Social Security Act.

A progress report from the Liaison Committee on Osteopathy stated that a report is being given to the Judicial Council for study. This report should appear before the House at the June meeting in New York.

A Commission on the cost of medical care was created.

Illinois Delegation

At the close of the Washington, D.C. session, an organization meeting was held; Dr. Arthur Goodyear was elected chairman of the Illinois delegation, and Dr. Leo P. A. Sweeney was re-elected secretary.

Based upon 10,251 members, the Illinois State Medical Society is entitled to eleven delegates and eleven alternate delegates to the AMA House. By official action, these 22 physicians, the president of the Society, the chairman of the Council and the secretary-treasurer attend both the June meeting and the clinical session in December. Each morning this group meets for breakfast and outlines the activities for that day —special meetings to attend; reference committees to cover; special groups to contact.

On the opening day of the meeting the Illinois State Medical Society is the host at a luncheon for all AMA officers, Council chairmen, members of the House of Delegates, the alternate delegates, and all state society officers in attendance. This luncheon has been given for several years at both the June meeting and the clinical session and has become traditional. At the Washington meeting in December, 1960, all members of Congress and their executive assistants were invited to attend. Only a few were in Washington at the time, since Congress was not in session, but letters of appreciation and thanks were received from many unable to attend.

Some members of the executive staff were present and assisted in the work of the Illinois delegation and in the routine activities in connection with the luncheon. Since the luncheon has been given, the Illinois headquarters delegation has done little or no entertaining, except to welcome Illinois physicians in attendance at the AMA meeting.

At the Miami and Washington meetings, our delegates and alternates were present, Dr. Percy E. Hopkins as member of the AMA Board of Trustees, Dr. Harry F. Dowling of Chicago as the delegate from the Section on Experimental Medicine and Therapeutics, and Dr. Edward L. Compere of Chicago as delegate from the Section on Orthopedic Surgery. These men also attended the Illinois luncheon and acted as hosts in the receiving line.

At the Miami meeting the following Illinois delegates were members of reference committees of the House:

Leo P. A. Sweeney	Committee on Medical Military Affairs
Frank H. Fowler	Committee on Reports of Officers
Carl F. Steinhoff	Committee on Rules and Order of Business

At the Washington meeting in December, Illinois men served as follows:

Walter C. Bornemeier	Chairman, Committee on Amendments to the Constitution and By-laws
Burtis E. Montgomery	Chairman, Committee on Reports of the Board of Trustees
Joseph T. O'Neill	Committee on Public Health and Occupational Health
Maurice M. Hoeltgen	Committee on Rules and Order of Business

It is the feeling of the members of the delegation that having the officers of the society, the alternate delegates, as well as members of the staff present at all meetings of the AMA House, has been of material assistance in establishing prestige for Illinois medicine.

Walter C. Bornemeier
Chairman
Leo P. A. Sweeney
Secretary
Harlan English
Frank Fowler
Arthur Goodyear
M. M. Hoeltgen
B. E. Montgomery
Joseph T. O'Neill
H. Kenneth Scatliff
Carl F. Steinhoff
C. Paul White

CHAIRMAN OF THE COUNCIL

The first meeting of the 1960-61 Council was held on June 26, 1960, and was followed by meetings on August 21, October 9, and December 11. Three additional meetings are scheduled before the 1961 Annual Meeting. A supplemental report will be presented at the first session of the House of Delegates.

Organization and Appointment of Committees

The chairman of the Council presented recommendations for committee appointments. They were approved and published with the Constitution and Bylaws, as amended at the 1960 Annual Meeting. The Council and its committees were thus prepared to consider the business before them. It included the large task of reorganization of staff and programs of the Society. This report indicates the major problem areas considered during the year. It should be understood, however, that much of the basic work was accomplished by committees. The details of their activities may be found in their reports, which I recommend for your reading and attention.

In the order of their initial consideration by the Council, including follow-up actions at later dates, we wish to report on the following actions and respectfully request approval as well as any comments which the House of Delegates may wish to make for the future guidance of the Council:

I. *Pilot Study for Early Detection of Glaucoma*

This project, conducted under the auspices of the Illinois Society for the Prevention of Blindness, was approved by the Council. It was designed so that each of fifty participating ophthalmologists would select two general practitioners or internists, who would perform tonometry on patients over 40 years of age as part of a complete physical examination. If tension were elevated, the patient was to be referred to an ophthalmologist. Information on the results of these studies is to be placed on IBM cards for statistical analysis. At the present time, a final report on the project has not been made available to the Council.

II. *Contact Lenses*

In follow-up action on a resolution passed at the June, 1960 meeting of the House of Delegates of the AMA, the Council approved calling the attention of the members of the ISMS to the dangers inherent in ill-fitting contact lenses. Several methods of educating the public and the profession were considered, and later the problem was presented to the Eye Health Committee. An editorial in the January, 1961 issue of the Illinois Medical Journal was the committee's first effort to alert the profession to the problem.

III. *Passage of Mills-Kerr Bill and Implementation in Illinois*

The 87th U.S. Congress passed the Mills-Kerr Bill in August, 1960, and the Society has made preparation for its implementation in Illinois.

Based upon the recommendations of the Medical Service Committee in June, the Council initiated support for the House version of the Social Security Bill HB12580. This, combined with the cooperation of other state medical societies, made possible the passage of the Mills-Kerr Bill in Congress as an alternative to the measure introduced by Representative Forand in favor of using the social security system as the basis for payment.

Subsequently, it was decided that the chairman of the council should appoint a special ad hoc committee to implement the Mills-Kerr Bill in Illinois. A draft of a bill is now available and has been discussed with the Governor. Further details will appear in the report of the Special Ad Hoc Committee, the Medical Service Committee, and the supplemental report of the chairman of the Council.

IV. *Chicago and Springfield Offices*

Consistent with the recommendations of the Special Session of the 1959 House of Delegates, the headquarters of the Illinois State Medical Society was established at 360 North Michigan Avenue, Chicago. An official opening was held on Oct. 7, 1960, and an informal reception for members of the Medical Society Executives Association, on Aug. 30, 1960. During the Republican National Convention it was the privilege of the Society officers in cooperation with the officers of the Chicago Medical Society to entertain physician delegates. Each of these meetings was successful and aided in establishing the new headquarters and its influence in the City of Chicago.

Within recent weeks a lease has been signed for the Springfield Regional Office at 520 South Sixth Street, Springfield. Appropriate office fur-

niture has been ordered, and the office was occupied on March 1, 1961. Appropriate appreciation of the Council is expressed to the members of the Special Committee: Drs. Harlan English as chairman, Jacob E. Reisch, and Harry Mantz.

V. *Administration of ISMS*

At the request of the Council, Mr. Richards, the executive administrator, will present a written report to the House of Delegates as well as an oral report on the progress made in the administrative reorganization of the Society. He will include therein all important changes in the administration of programs and additions to the staff. However, the Council is responsible for financing the operation of the Society based upon the dues structure established by the House of Delegates. Therefore, a budget for the fiscal year, January 1 through December 31, 1961 will be distributed by the Council to each member of the House of Delegates along with the audit for the eight months' operation from May 1 to December 31, 1960. This is in line with the request of the House of Delegates at its 1960 sessions. It is particularly significant that reserves amounting to $154,451.78 are now established. (See auditor's report May 1 through December 31, 1961.) Provision is made in the 1961 budget to increase these reserves modestly. It was the Council's expectation that these reserves would be considerably less by the time of complete staff reorganization, but it has been completed on less money than anticipated.

I hope the House will recognize that program and staff services will not be functioning to their ultimate capacity for several more years. Mr. Richards pointed this out in his presentation to the 1960 House of Delegates. Significant progress has been made in the past seven months, but more can be anticipated. Staff members now employed by Mr. Richards are of the highest calibre available for the authorized salaries. I believe that many of the House members will be fully aware of the excellent staff by the time of the annual meeting, and will enjoy the opportunity of working with them in the future.

VI. *District Meetings*

As recommended by the executive administrator, all councilors have conducted or are planning to hold district meetings to discuss medical society problems and explain the reorganization of the Society. The Council has financed these meetings as a means of securing grass roots opinions and of introducing the new staff.

As anticipated, many constructive suggestions and comments have been received. Some are already being implemented by the Council and committee action. Many others are being considered for future implementation, and others are receiving crystalization of opinion. The Council is most appreciative of the time given by the officers and members of county medical societies to attend these meetings. It is also appreciative of the time given by staff members to travel to each area during weekends when they might have been with their families.

During the current year some councilors will hold additional district meetings. These have been provided for in the 1961 budget, and county medical societies will be notified when and if a meeting is to be called in their area.

VII. *Committee to Work with New Home Committee of CMS*

At the 1960 annual meeting the House of Delegates authorized the president to appoint a committee to work with the New Home Committee of the Chicago Medical Society. A report of this committee's activities will be found elsewhere in the reports to the House of Delegates. However, it is mentioned here so that the House will understand that the Council has indicated support for the committee's recommendations. We heartily endorse the proposal that if and when the Chicago Medical Society should decide to purchase and remodel the property mentioned in the report that the Illinois State Medical Society should rent and occupy 6,000 to 10,000 square feet of space therein.

VIII. *Committee to Consider a Relative Value Study*

In line with the recommendations of the 1960 House of Delegates, the chairman of the Council appointed a special committee to consider the merits of conducting a Relative Value Study. After its initial meeting, the committee recommended regional meetings to explore the "Study" idea with the general membership of ISMS. Such meetings are presently being arranged, and a final report of the committee will be presented directly to the House. At this time the Council has no official opinion on whether or not a Rela-

tive Value Study should be implemented in this state.

IX. *Appointment of Examining Panel*

Resolution No. 18 of the 1960 House requested that an Examining Panel be created by the Council for use by the State Department of Registration and Education in the event of need. Such a panel was submitted to and acknowledged by the director of the department.

X. *Committee on Problems of Those Over 65 Years of Age*

In the consideration of resolutions introduced at the 1960 House of Delegates on the problems of those over 65, and at the request of the House, the chairman of the Council appointed a special committee to review previous actions and report to the Council on the subject. This committee has not made its report at the time of writing, but it will be included in a supplementary or separate report to the House of Delegates.

XI. *Alteration of Employees' Retirement Plan*

After due consideration certain alterations were made in the Employee's Retirement Plan which made it possible for employees (1) to begin participation one year from the anniversary date of their employment, and (2) to be continued in employment after age 65 if the Society so desires, subject to a physical examination.

XII. *Recommendation on Place of Annual Meeting for 1963*

The House of Delegates requested the Council to make recommendations regarding the place of the Annual Meeting for 1963. At the request of the executive administrator, the Council has designated him as responsible for investigating the Chicago hotels for the 1963 meeting. The Council has been holding meetings in several hotels with a view toward objectively evaluating the facilities available. A final recommendation will be placed before the House of Delegates as a part of its supplementary report.

XIII. *Implementation of the AMA and ISMS Resolutions*

The Council feels it is not necessary to report in detail on the implementation of AMA resolutions. However, it wishes to assure the House of Delegates that it has reviewed the actions of the AMA, and has referred to appropriate committees and officers the implementation of AMA resolutions with which the Illinois delegation and the Council agrees.

Committees will report to the House of Delegates on resolutions referred to them for implementation since the last meeting of the ISMS House of Delegates. A complete record of these referrals is maintained by the executive administrator and may be requested at any time.

XIV. *Publication of Abstracts of Council Actions*

We are pleased to report that abstracts of important Council actions have been included in the Journal immediately following the meetings of the Council during this current year. Sufficient comments from members who have read these abstracts support continued publication. The abstracts have made it possible to eliminate publication of detailed minutes of the Council. However, complete minutes are available to any member. The Council does not wish to keep information from the general membership but feels that by publishing the abstracts in a more readable style, the membership will be more prone to read and digest the important features of Council sessions.

XV. *Establishment of Illinois Medical Political Action Committee*

At the 1960 meeting of the House of Delegates there was discussion and a resolution passed regarding the formation of a political education committee by the Illinois State Medical Society. A review of the legality of this type of organization indicated that the ISMS would not be within its sphere of proper activity if it sponsored the formation of such an organization. It was, therefore, the decision of the Council that it should not form such a committee.

The Council does wish to note, however, that in recent months individual physicians interested in political education have joined together to form what is now known as the Illinois Medical Political Action Committee. It is a separate corporation, with its own offices, its own executive director, and staff. Membership is open to any member of the ISMS who wishes to subscribe and support its activities and purposes. We trust it is amply clear to the members of the House of

Delegates that no committee funds or staff of the Society have been used to implement the program of IMPAC.

XVI. *Implementation of Resolution No. 17 of the 1960 House of Delegates*

This resolution reads in part:

"That ISMS Advisory Committee to IPAC request a change and modification of this ruling, so as to permit the oral (telephone) ordering by physicians of prescriptions to IPAC recipients to pharmacists of IPAC recipients' choice, with the further provision that the physician mail or otherwise transmit with reasonable promptness to the pharmacist a written prescription to cover the original verbal order, and all refills be authorized."

At the Aug. 21, 1960 meeting, the chairman of the Advisory Committee to the IPAC reported on his committee's investigation on the use of oral prescriptions, and the effect on the administration of the IPAC. Because the House of Delegates in 1960 did not have at its disposal complete information which has been furnished to the Council, the Council has supported the action of the Commission in not permitting oral prescriptions. The chairman of the IPAC committee will no doubt report in further detail and will also make himself available to discuss this at appropriate reference committee hearings.

XVII. *Per diem for Officers, Delegates, and Committee Members*

By action of the Council a per diem of $15 has been granted to officers, AMA delegates, alternate delegates, councilors, and members of committees attending meetings in the interest of ISMS. This policy is set forth on the expense voucher to be submitted by those attending meetings, and is in addition to expenses which may be incurred for transportation, hotel, meals, and the like.

XVIII. *Reports of the Director of the Department of Public Health, and Department of Public Welfare*

It should be noted that the directors of the Departments of Public Health and Public Welfare attend Council meetings and present progress reports. Their presence is most advisable and is helpful to the Council in understanding the functions of these departments. Some of the more important items which were reported and approved by the Council were:

1. A survey to be made by the Department of Vital Statistics in the field of arteriosclerosis.

2. A revision of the Premarital Examinations under existing laws.

3. A survey by the National Office of Vital Statistics to obtain national estimates of hospitalization utilization by a study of records of deceased persons in the twelve-month periods prior to death. A national sample of approximately 3,000 deaths occurring during 1960-61 will be selected from the mortality samples.

4. The continued support of the mental health program, which will be reported on more fully by the Committee on Mental Health.

XIX. *Presentation of AMEF Contribution by ISMS*

In the past, the Council has authorized the presentation of the AMEF contribution at the June session of the AMA meeting. In view of changes in bookkeeping procedures, and in order to make the contribution as large as possible, it has been decided to delay this presentation until December at the Clinical Session of the AMA.

XX. *Resolution to the Governor*

At the October 9 meeting the Council expressed grave concern regarding the lowering of standards of medical care for residents of Illinois through the procedures being used by the Department of Registration and Education. Appendix 1 is the text of a resolution which was submitted to the Governor. As a result of this and other contacts, we are pleased to report that the director of the Department of Registration and Education has submitted an adequate budget for the next biennium to provide the necessary staff to implement a program of investigation visualized by the Illinois State Medical Society when it advocated a biennial re-registration of physicians at a fee of $6. It is the Council's opinion that the change in administration will also bring a change in the directorship of this department, and that a cooperative attitude will be presented. We hope to continue to extend our influence in this area.

XXI. *Term of office of Delegates to ISMS*

A legal opinion prepared by the General

Counsel of ISMS indicates that the term of office of delegates to the ISMS, according to our Constitution and Bylaws, should run from January 1 of each year through December 31 of that same year. Unless the House should deem it otherwise, the Council will follow this interpretation.

XXII. *Criticism of Springfield Newsletter*

Introduced at the 1960 session of the House of Delegates were resolutions 4, 5, 6, 9, and 11, for which a substitute resolution was offered and passed:

"Whereas, Socialism in all its forms is detrimental to the health and welfare of our nation,

NOW THEREFORE BE IT RESOLVED That the ISMS exert its influence against all forms of socialism, both medical and non-medical, and

BE IT FURTHER RESOLVED That the ISMS urge its component medical societies to encourage doctors to form political action committees, and to implement the financing of these committees by any legal means."

The implementation of this resolution was assigned to the Committee on Medical Service. Through its staff director and in cooperation with the executive administrator, extreme efforts have been made to advise the entire membership of the Illinois State Medical Society regarding encroachments upon the private practice of medicine, and upon private enterprise.

The above resolution was interpreted by the Council to mean that every effort should be exerted to keep the membership informed and up-to-date. The mailing list of the Springfield Newsletter was, therefore, expanded to include all members. However, some members have chosen to criticize the content of the Springfield Newsletter, which has continually espoused the above policy of the House of Delegates.

The Council chairman feels certain that the majority of the members of the House of Delegates will continue to support Council efforts in this area. We take cognizance of the disagreements by some of our members and wish the House of Delegates to consider the repercussions, as well as the attitude of some of our members with respect to support of the Society, when it assigns to the Council the implementation of such a resolution. It should also be noted here that the same reference committee stated in its report at the 1960 meeting of the House of Delegates, "We hope that the circulation of the Springfield Newsletter will eventually be extended to every member of our society." The chairman of the Council suggests that the reference committee and the House of Delegates look closely at the results of this recommendation, and advise the Council as to its future course of action.

XXIII. *Loan Plan for Physicians*

The Council was presented with a plan by the Continental Illinois National Bank & Trust Company of Chicago in which they offered to make loans to physicians starting practice. This plan is also available to those already in practice to enable them to finance any remodeling costs or purchase of new equipment. The Council has approved the dissemination of this information to five county medical societies surrounding Chicago. The only eligibility provision made by the bank upon the physician is that he be a member of the ISMS. Up to $5,000 is available, with no payments during the first six months of the loan. Loans are granted on an individual basis. Our experience indicates that physicians are now using this service. In the event physicians in other counties would like to make use of this service, we feel sure that the Continental Illinois National Bank & Trust Company of Chicago will consider their applications without delay.

XXIV. *Budget for 1961*

Consistent with the desires of the House of Delegates, we will submit to each of the delegates a copy of the budget for the 1961 calendar year—January 1 through December 31, 1961. This budget was approved by the Finance Committee and also by the Council. It has been in operation for several months at the time of the preparation of this report. We feel it is an adequate budget. It is also a maximum budget. We have directed the executive administrator to remain within the confines of this budget, and if possible, provide for additions to our present reserves. The chairman of the Council, the chairman of the Finance Committee, and the executive administrator will be available to discuss the budget for 1961 at the reference committee hearing.

XXV. *Second National Conference on Medical Aspects of Sports*

At the request of the American Medical Association, the chairman of the Council was pleased to request Dr. Eugene T. McEnery to attend the Second National Conference on Medical Aspects of Sports held in conjunction with the Clinical Session of the AMA in Washington, D. C. Dr. McEnery's written report on this item was included in the January issue of the Illinois Medical Journal. Dr. McEnery and Dr. Reichert of the Council stressed the importance of participation by physicians in the athletic injury program and called attention of the Council to the fact that it has taken the medical profession twenty years to become active in this area, particularly with respect to the child in the elementary school. It is hoped that more members of the medical profession will participate in this most important program.

XXVI. *Resolution Regarding the Practice of Laboratory Medicine*

A resolution was presented to the Council by the Lake County Medical Society concerning the practice of laboratory medicine. This resolution was referred to the Committee on Medical Service and the general counsel for discussion and report to the Council. At the time of the preparation of this report, we know that another resolution will be introduced by the Winnebago County Medical Society covering this subject. We anticipate that by the time of the annual meeting the Committee on Medical Service will have concluded its discussion and will report further on its conclusion. It can be pointed out that the Council was generally in agreement with the resolution. However, we feel that the House of Delegates should establish the policy with respect to this area of medical practice.

XXVII. *Educational Program and Field Contacts*

At the January 29 meeting of the Council a program for the implementation of the Mills-Kerr Bill and an educational program toward the use of private insurance to provide medical and surgical coverage was approved by the Council and given A-1 priority with respect to staff time. More detailed material will be presented to the membership of the House of Delegates and county medical societies prior to the time of the meeting of the House of Delegates. It is hoped that staff members will contact each of the 92 county medical societies within the next several months.

XXVIII. *Attendance at White House Conference on Aging*

Although more details will be found in the report of the Committee on Aging, it is important that the Council make note of the fact that fifteen physicians from Illinois attended the White House Conference on Aging Jan. 8 through 12, 1961. The accusation that medicine had this conference stacked was a deliberate and falsified smear effort, because labor, social scientists, and their friends outnumbered the physicians and those who shared our views. There was a total of 2,475 delegates. There were 265 or less in the section on Income Maintenance. Since only sections voted, it was incorrectly stated that the Conference supported the social security system. The Council was most appreciative of the activities of those fifteen physicians who took the time to go to the White House Conference and present the views of medicine with respect to the care of the aged.

XXIX. *Development of Medical Service Areas*

In the organization of county medical societies it should be pointed out that we have many very small county medical societies, some with as few as two members. We also have some large county medical societies with as many as 6,300 members. In a study prepared by the AMA in 1951 it was pointed out that in Illinois there are 25 medical service areas. These are areas in which people tend to move toward the center in order to seek their medical care. The Council has authorized our executive administrator to prepare a discussion of these medical service areas and present it to the House of Delegates for its consideration.

Some county medical societies are considering the employment of paid executive secretaries, and at least eight county medical societies now have either part-or-full-time paid executive secretaries. It is important that a discussion of this problem be presented to the House of Delegates, so that you may be aware of what the potential development of these areas might bring forth with respect to the possible combination of coun-

ty medical societies to result in finer service to the medical profession, and most important, to the public.

XXX. *Distribution of Pamphlet: "Cost of Medical Care"*

The Council authorized the director of the Division of Medical Services and Economic Research to plan for the distribution of the pamphlet prepared by the AMA on the cost of medical care. It is hoped that the membership will use this pamphlet to its best advantage, and make it available to patients in order to explain the comparison of the cost of physician care, as compared with the cost of other items of medical service. At the time of preparation of this report, many requests have been received, but it is important that use of this pamphlet be continued in order to educate the public on these items.

XXXI. *Comment*

Because there will be three meetings of the Council before the Annual Meeting, a supplemental report will be required. This report is necessarily lengthy but covers all items of importance considered by the Council. Your chairman wishes to extend his appreciation to the Council and staff members for their fine attention to their duties during this past year.

E. A. Piszczek
Chairman

RESOLUTION

WHEREAS the laws of the state of Illinois contemplate that all matters pertaining to the education, examination, licensure and regulation of many of the trades and learned professions are best and most effectively administered by well qualified and widely respected members of the respective trades and professions; and

WHEREAS the Civil Administrative Code of Illinois requires that in making appointments to the Medical Examining Committee, the Director of the Department of Registration and Education shall seek the counsel and recommendations of the professional organizations concerned; and

WHEREAS the Medical Practice Act of Illinois provides that the Director of the Department of Registration and Education shall exercise the powers of that office only upon the written direction of a majority of the members of the Medical Examining Committee; and

WHEREAS the incumbent director has quite recently seen fit to fill a vacancy in the physician membership of the Medical Examining Committee without consulting the Illinois State Medical Society or, so far as is known, any medical society or organization; and

WHEREAS it appears that over a considerable period of time, the incumbent director has upon numerous occasions failed or refused to act in conformity with the recommendations of a majority of the members of the Medical Examining Committee, has assumed and exercised many of the powers and prerogatives of the Medical Examining Committee, and has attempted to coerce the Committee to alter or withdraw certain of its decisions, and in general is failing to give the Medical Examining Committee the kind of cooperation which is essential to sound and effective administration of the Medical Practice Act; and

WHEREAS these circumstances have been the cause of severe and continuing criticism of the Department and of the Medical Examining Committee;

NOW THEREFORE BE IT RESOLVED that the Council of the Illinois State Medical Society does hereby express grave concern with regard to these matters which are of such vital significance to the health and safety of all the citizens of Illinois; and

BE IT FURTHER RESOLVED that the Officers of the Illinois State Medical Society be and they are hereby directed to request the Honorable William G. Stratton, Governor of Illinois, to receive representatives of the Illinois State Medical Society for the purpose of discussing the serious problems involved; and

BE IT FURTHER RESOLVED that copies of this resolution be forwarded to the Honorable William G. Stratton, Governor, and to the Honorable Vera M. Binks, Director of the Department of Registration and Education of the State of Illinois.

Adopted by the Council of the Illinois State Medical Society at Chicago, Illinois, this ninth day of October, 1960.

E. A. Piszczek, Chairman of the Council of the Illinois State Medical Society

Reports on the Journal

EDITOR

During the last 12 months our Journal has contained many more articles than any time in its history and 104 pages more than in the preceding 12 months. In addition, we prepared and published the extensive minutes of the House of Delegates' special meeting in December, 1959, and the complete program and the reports of officers and committees of the House of Delegates for the 1960 annual meeting, which were reprinted, with additions, as the Handbook.

At the same time we have attempted to improve the appearance of the Journal by varying layout of pages, eliminating heavy black type faces and large expanses of white space, by obtaining more illustrations for articles and news and better reproduction of them, and by using a seasonal cover for the Christmas issue. However, we are far from satisfied and hope to improve particularly the printing and typography.

The organization of material within our pages has been improved. The section for editorials is weeded of news; the old "Correspondence" section is renamed more properly "Announcements," and we have added a section Official Business for state society announcements.

During the year we added four new monthly features: The Secretary's Newsletter, The View Box, Medicine in the Out-of-Doors, and Correspondence from readers. Features dropped by administrative request were the Secretary's Newsletter and the P.R. Page from the Public Relations Department.

A total of 142 articles have been submitted and 116, or 19 more than in the previous 12 months, have been published.

We have brought our readers an increased number of scientific editorials signed by Illinois physicians recognized as leaders in their fields. Hundreds of items digesting news in and on the periphery of medicine and medical practice have appeared in Editor's Desk now running 3 to 4 pages per issue rather than 2 to 3.

At the same time, additional duties have been added to the editorial office. We are charged with layout and marking copy for type, and the time-consuming paste-up of pages for the printer, editing and marking copy of reports contained in the annual meeting Handbook, and preparation of the index of the Journal.

Preparation of Council Minutes has been taken over by the administrative staff.

By the time of the annual meeting we will have mailed loose leaf booklets of Reference Sheets with accompanying letters to libraries of the five medical schools and over 200 accredited hospitals in the state.

A statistical analysis of the regular features of the Journal from March, 1960 through February, 1961 shows we have published a total of 840 pages, an increase of 104 over the preceding 12 month period; 424 pages of clinical articles; 43 pages of editorials, 34 of Editor's Desk; 40 pages of Announcements; 57 of News of the State; and 25 Book Review pages.

We have been gratified by the favorable response of authors to the editing of their articles, by requests for the References Pages, and by the letters of comment, suggestion, and criticism that have been sent to your editor during the latter part of the year. On the other hand, we are concerned over the sparcity of timely news from county societies.

We wish to thank those physicians who have written guest editorials and book reviews for us, and particularly our regular contributors, Dr. Robert Freeark and Dr. Robert Baker of Cook County Hospital, for preparation of the clinical-surgical conferences; Dr. Richard J. Jones and Dr. C. Bruce Taylor of the Chicago Heart Association; Dr. Franz Gampl, also of Cook County Hospital, for the View Box; and Dr. Julius M. Kowalski of Princeton for Medicine in the Out-of-Doors. Thanks are due Mr. Ed Malley, our advertising manager, for keeping us solvent, and Mr. Al Boeck, publications director, and to the Editorial Committee also for all their help in selecting articles for publication.

I make the following recommendations for the coming year:

1. That the News of the State be reorganized to eliminate names of counties.
2. That production duties be moved from the editorial department.
3. That a better grade of paper be secured for printing to eliminate print-through and to secure better reproduction of pictures.
4. That color not dependent on color in advertising be added to inner pages of the Journal.

5. That evaluation of papers submitted be assigned to members of the Editorial Committee to speed acceptance or rejection notices to authors.

T. R. Van Dellen
Editor, Illinois Medical Journal

ADDENDUM

The following helpful motion was made and passed at the meeting of the Editorial Board and Journal Committee February 22 following preparation of the above report. "The editor has the final authority in accepting or rejecting a manuscript; but any paper which, in his opinion, is controversial or in need of review, will be sent to the appropriate member or members of the board or to appropriate authority."

JOURNAL COMMITTEE

The Journal Committee held a combined meeting with the Editorial Board on Oct. 26, 1960; another meeting is scheduled for February 22 and additional meetings will undoubtedly be held before the annual meeting.

During the past year a marked reorganization has taken place in various aspects of the publication of the Journal. This activity can probably best be summarized as one of cautious and thorough exploration. The Journal Committee, along with the editor and the director of publications, is investigating many facets concerned with the production of an outstanding publication, major among which are (1) the format, (2) the typography, (3) the cover, (4) the printing, (5) the advertising, and (6) the introduction of new features.

It is the opinion of the Journal Committee that the Journal can be made not only the most medically informative state medical journal in these 50 states by some additions to its editorial content but also more appealing and readable by changes in its format. To accomplish this, the committee has discussed the retaining of a publications designer to restyle the magazine. Included with this revision would be recommendations for a new cover. It is to be noted that all projects of this nature will be accomplished within the present budget framework of the department.

It should be stated that the advertising in the Journal, which is the prime source of finance for its publication, has remained at practically the same level as that of a year ago, despite the recent furor concerning "drugs and drug manufacturers" in Congressional hearings.

During the past year much constructive criticism of the Journal (as well as many complaints) have been received from the general membership at the district staff meetings held in each councilor district. These meetings have provided the forum whereby the director of publications has been able to learn of the likes and dislikes of the members, why they don't read the Journal, and what (it is hoped) will induce them to read it if changes and additions are made. Though no sudden or dramatic change is projected for a certain target date, it can be prophesied that by a year from now our members will be receiving a much improved publication.

Jacob E. Reisch, *Chairman*
W. H. Palmer
Albert VanderKloot
Paul P. Youngberg
Joseph T. O'Neill

REPORT OF THE EDITORIAL BOARD

The Editorial Board of the Illinois Medical Journal met with the Journal Committee on Oct. 26, 1960, and again on Feb. 22, 1961. The members of the Editorial Board participated in these meetings and in the general discussions of the business affairs, contract for printing, format, and general content of the Journal.

The Editorial Board has continued to have a sincere interest and a desire to function in the responsibilities delegated by the Council to this group. The members of the board have given suggestions and advice at the joint meetings, but have not been called upon to evaluate manuscripts submitted to the Journal for publication. At the meeting on Feb. 22, 1961, these items were discussed, and also other services by which the board could assist the editor. The editor agreed to refer selected manuscripts to members of the board for advisement. He suggested that the board could aid in the preparation of editorials, and also help in devising ways to improve the Journal.

Edwin F. Hirsch, *Chairman*
James H. Hutton
John R. Wolff
Frederick H. Falls
Edward F. Webb
Arkell M. Vaughn
Samuel A. Levinson
Francis L. Lederer
Jacob E. Reisch
James Cross

COMMITTEE ON ARCHIVES

Recommendation 1: That the secretary of each component county society report current items of historical interest to the "News to the State" section of the Illinois Medical Journal. This will insure the preservation of such material in a place where it will always be accessible.

Recommendation 2: That other items of interest be sent to the chairman of the Committee on Archives.

Recommendation 3: That any physician in our society who has in his possession historical material, such as old records, old licenses to practice medicine, old fee bills, records pertaining to activities of pioneer physicians, or to early medical societies, send these articles to the chairman of the Committee on Archives.

These recommendations are made for the obvious purpose of preventing the destruction of valuable records which would be preserved by the Society.

This committee has had no formal meetings during the year, to date. Necessary business has been conducted by telephone.

Dr. Youngberg's suggestion that various hospital staffs throughout the state should be interested in and encouraged to collect items mentioned above, as well as old medical books and instruments, is still a very excellent idea. These things will make an interesting display if placed in suitable cases or cabinets in our hospital libraries. It should stimulate the interest of staff members in finding and collecting such items.

Your committee is preparing a request for cooperation of component county societies in carrying this work forward.

Tom Kirkwood
Chairman
J. J. Moore
Secretary
Paul P. Youngberg

COMMITTEE ON BENEVOLENCE

The Benevolence Fund, although established over 20 years ago, needs additional publicity through all media available. The committee recommends that the House of Delegates approve the publication of background material, committee history, and perhaps interesting case material in the Journal, short articles in Pulse, and also in county medical society bulletins whenever they are available for our use.

The cost of maintaining the present number of recipients runs approximately $3,000 a month. A sum of $2 is allocated automatically from the dues of each physician. With a membership of some 9,600 dues-paying members, this does not make it possible to maintain the benevolence activity out of current dues. Fortunately, the Woman's Auxiliary has been more than generous through the years and has contributed to the fund annually.

Of the 45 recipients, well over half are widows of former members, so the activities of the Auxiliary are sincerely appreciated by the wives of physicians receiving assistance from the fund.

Total assets on Dec. 31, 1960, following the annual audit for the calendar year, were $160,313.26. This included cash in the bank (both in checking and saving accounts), and the investments held in the name of the Benevolence Committee. We have bonds totalling $140,000 face value held in the trust department at the Continental Illinois National Bank.

The committee hopes to develop a much more efficient means of investigating cases when assistance is requested. It is not too difficult to get information in the smaller counties, but the problem is serious in and around Chicago.

The most that can be given to any one individual without special action on the part of the Council is $100 a month. The amount paid to recipients varies greatly, and it is the opinion of the committee that many cases should be reinvestigated. We hope that we can assign these investigations to our own employees since the committee discontinued the use of the agency investigations of applicants due to the fact that results were minimum and the cost involved became more than we felt was practical.

The committee has no specific requests to make of the House other than to stress the importance of the committee and its work. We feel that each member of the House of Delegates has

a definite responsibility to take back to his county society information about what is being done for needy members, their widows, or their dependent children.

We feel that this is a part of the benefits given to members if and when the need arises. We wish to call your attention to the fact that no check is ever written on this fund except to a recipient. The expenses of the committee and the investigations are all paid from the general funds of the Society.

The committee wishes to thank the officers of the local county medical societies in communities where investigations have been made and where they have been of great assistance in determining the amount of need and whether or not the recipient is entitled to benefits.

Norman L. Sheehe
Chairman
Irving H. Neece
F. M. Nicholson

GRIEVANCE COMMITTEE

Report not available at this time.

COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

Report not available at this time.

COMMITTEE ON MEDICAL SERVICE

There is a new administration in the White House. Administrations come and go, some of them Democratic and some Republican, but our nation continues to prosper and grow. We congratulate the winners in the nation, the state, and the counties and wish them all well. Just about half of the voters in the United States are disappointed in the outcome of the national election. Mr. Kennedy is accepted as the chief executive of the land, and we will acknowledge his constitutional authority and give him every assistance. We are not, however, obliged to agree with everything he says and does. In fact, under the concept of majority rule, we will accept that which we feel is in the public interest but accept our responsibility to disagree with that which we do not feel is in the public interest, and we will not hesitate to speak — in fact, it is our duty to speak up and to advocate the things we believe in.

At the time of this report, your committee has had three formal meetings, but your chairman has attended several other meetings which are related to our areas of interest. In addition, he is in almost daily contact with our General Counsel on legislative matters.

In accordance with the wishes of the House of Delegates, the *Springfield Newsletter* is now being sent to all members of the society. There have been many compliments and a few criticisms. Basically, a newsletter is an excellent method of keeping our members informed of current developments.

The 72nd Illinois General Assembly convened in January of this year. Our most important proposal is a bill to implement the Mills-Kerr Bill. At the time of the preparation of this report, your committee has given tentative approval to Draft VI of a bill which would set up fairly liberal eligibility tests for participation in a full program of medical care by near-needy aged persons. Conversations have gone forward with other interested organizations and agencies.

Among other proposals under study by your committee is a bill to permit the incorporation of medical partnerships in Illinois to take advantage of the *Kintner* decision, permitting the deferment of income for retirement purposes. The problem of the mail order laboratory is receiving study. The committee and the Council have approved legislation to change the Medical Practice Act to permit counties instead of the State of Illinois to recover the fines and recoveries under the act, in an effort to encourage State's Attorneys to prosecute violations of the act; a bill to delete the midwife section from the act; the addition of the following provision to the act as grounds for suspension or revocation of license; "engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public;" provision for revocation of a license obtained by reciprocity when the license upon which it is based has been revoked. Your committee also has under consideration legislation to protect the confidentiality of reports of tissue and maternal welfare committees in hospitals; a bill to give the medical examining committee more autonomy within the Department of Registration and Education; a proposal to designate a special assistant attorney general to service the Department of Registration & Education in the enforcement of the Medical Practice Act. Also receiving attention is the matter of sterilization, the matter

of funnelling re-registration fees of physicians into the Department of Registration & Education for better enforcement of the Medical Practice Act, the suggestion that the Administration of Estates Act to be amended to give physician claims higher priority in the settlement of estates.

President Kennedy made public announcement of his medical care program on Feb. 9, 1961. Essentially his program would provide "free" hospitalization and nursing home care plus certain extras to recipients under social security. There is a deductible feature of $10 per day for the first 9 days. The program will also include provision for federal grants for construction of medical and dental schools, nursing homes, more federal control over medical research; federal scholarships for medical and dental students; establishment of a national institute for child health and human development; expanded rehabilitation; removal of limitations on federal payments for indirect costs of medical research projects. Thus the Forand Bill with certain refinements minus physician services again becomes an issue in the national Congress. This plan would extend governmental control over hospitals, nursing homes, pre-empt the field of medical research, extend the government into the field of medical education— in short, provide a crutch without which medical institutions would be unable to operate in the future. Once this program is enacted, physician services would be added. If we are to fight off complete control over the private practice of medicine through this piecemeal approach, our members will have to dedicate themselves individually to make the maximum effort during the coming year. Anything less is bound to result in a program of governmental ownership or control over the dispensers of medical care. that is, socialism in medicine.

We urge every physician to join with his professional organization to preserve our way of life for our children and grandchildren.

Richard J. Bennett
Chairman
Ralph N. Redmond
J. Ernest Breed
V. P. Siegel
John H. Mathis
H. Close Hesseltine
Jacob E. Reisch

MEDICAL TESTIMONY COMMITTEE

During the year no complaints nor suggestions came to the attention of your committee.

Leo P. A. Sweeney
Chairman
Harry D. Nesmith
John H. Gilmore
Maurice D. Murfin
Joseph H. Chivers
Peter Rumore
Joseph F. O'Malley
William K. Ford

MEDICO LEGAL COMMITTEE

Your committee has been quite active. Presently under study are insurance problems incurred by physicians and the problem of what explanations a physician should discuss with patients confronted with the various consent forms.

Your committee extends its sincere appreciation to the Council and officers of the Illinois State Medical Society for their continuous cooperation and support.

George C. Turner
Chairman
Charles Allison
Leo P. A. Sweeney
F. E. Bihss
Edward C. Helfers
Ralph McReynolds

COMMITTEE ON PREPAYMENT PLANS AND ORGANIZATIONS

Report not available at this time.

COMMITTEE ON PUBLIC RELATIONS

Report not available at this time.

Appendix to Public Relations Report

PHYSICIANS PLACEMENT SERVICE

The activities of the Physicians Placement Service of this Society, formerly a part of the secretary's annual report, are now under the direction of the Division of Public Relations.

Although on March 1, 1961, there were 131 communities listed with our placement service as needing additional general practitioners, there is no great concern about the magnitude of the number. One factor that produces a pseudo-shortage is that many communities which have supported a resident physician for many years

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BALTIMORE

apparently expect to have him replaced at his death, even though they are minutes by car from physicians in the next town; this was not the case when the deceased physician located in the community in question.

We list very few communities not verified by the local medical society as being in true need of a physician. The exceptions are openings for associates for members of the Society, and a limited number of openings in Cook County. Although there is no shortage of physicians in Cook County, we do list some opportunities that come to our attention, since a few of our registrants specify they are not interested in locating outside of the Greater Chicago area.

At present, 112 general practitioners are registered with our Physicians Placement Service. A few are members, but the majority have only recently completed their internships or residencies; others have just been released from military service, and the rest are dissatisfied with their present locations. All are prospective members. The list changes from day to day as new names are added and others deleted. The above number includes 42 who have been referred to us by the American Medical Association, and 70 who have registered directly with our service. In the specialty category, about 275 physicians are now listed, most of whom were referred to us by the AMA.

Since June, 1960, 132 general practitioners and 37 specialists have been removed from the mailing list because we were advised that they were satisfactorily located.

We have received more telephone requests from physicians interested in receiving help from our placement service since the office moved from Monmouth. There has been an increase also in the number of physicians who have called on us at the office. On the other hand, the number of communities that have sent representatives to the office has decreased since the office moved from Monmouth, but we feel that we can give them the same service by mail.

It is interesting to note that in our 1958 report we stated that our placement service had been instrumental in providing 178 communities with general practitioners during the previous five years, which compared very favorably with the results in other states, according to the AMA. The following year 30 additional openings for general practitioners and nine for specialists had been added. In 1960 our annual report showed we had found general practitioners for an additional 23 communities, and 19 openings for specialists had been filled.

We are pleased to report 36 openings filled since our last annual report, although our report is being compiled a month earlier than in the past. We have filled openings for general practitioners in the following communities: Walnut, Martinsville, Oakland, Villa Park, Effingham, Kewanee, Newton, McLeansboro, Chebanse, Antioch, Winthrop Harbor, Mount Olive, New Boston, Polo, Chillicothe, Coal Valley, Orland Park, Lyons, and Toledo. In addition, we assisted four Chicago physicians in finding associates. Physicians were found also for the following downstate communities which had been on our placement service mailing list for some time, although the physicians who filled the openings were not from our mailing list: Farina, St. Elmo, London Mills, Granite City, and Murrayville. We also successfully filled openings for specialists in Geneseo, Galesburg, Springfield, Paris, Decatur, DeKalb, and Champaign. Since the Physicians Placement Service of the AMA is presently under revision, no current statistics are available, but in the past we have ranked with the "Top 4" in the percentage of openings filled.

The Physicians Placement Service welcomes suggestions from members of the House of Delegates for additional ways of serving our members and prospective members, as well as the communities throughout the state in need of additional physicians.

Reports of Council Committees

ADVISORY COMMITTEES OF THE COUNCIL

To: Dependents Medical Care Program

The Medicare Program for Dependents of Uniformed Service personnel completed four years of operation in December, 1960. For the 12 months ending Dec. 31, 1960, a total of 5,624 patients were served in Illinois with payments to physicians totalling $512,310. This was roughly 500 less cases than reported for 1959. However, a strict comparison on this basis is subject to error due to delays in the reporting of claims. A breakdown of 1960 cases by category follows:

3,103	Obstetrical (this includes miscarriages, incomplete abortion, and isolated antepartum care)
30	Premature Care
217	Normal Newborn Care
10	Complete Rh Transfusion
959	General Medical Care (including infants and children)
77	Fractures
144	Bodily Injury
205	Gynecology Surgery
525	General Surgery
354	Anesthesia
5,624	Total cases for the period

Effective Aug. 1, 1960, the contract between the society and the government, under which this program operates, was renewed for another year without change. The Illinois Medical Service (Chicago Blue Shield Plan) continues as fiscal administrator. During the year no formal complaints were brought before the committee from individual physicians or county societies; consequently no formal meetings of the committee were held.

Percy E. Hopkins
Chairman
Edwin S. Hamilton
Joseph T. O'Neill
Walter C. Bornemeier
Norris L. Brookens
J. Stuart Moffat
Ex-officio:
H. Close Hesseltine
E. A. Piszczek
Jacob E. Reisch

To: Governmental Medical Services

Report not available at this time.

SUBCOMMITTEES:

LIAISON ILLINOIS DIVISION AMERICAN LEGION

No report to be submitted.

CIVIL DEFENSE COMMITTEE

Report not available at this time.

CORONERS' COMMITTEE

The committee on cooperation with the county coroners of the State of Illinois to improve the quality of the medical examinations of cases referred for investigation is pleased to report continuous progress in downstate counties and especially in Cook County.

The last General Assembly appropriated $200,000 for the establishment of toxicological laboratories in the Department of Public Health, one at Springfield for the southern tier of downstate counties, and another for the northern tier of downstate counties in the Branch Laboratory at 1800 W. Fillmore St., Chicago. After considerable search and effort, a well qualified toxicologist was secured and appointed, and is establishing the laboratory in Chicago.

In Cook County, implemented by the Citizens Advisory Committee to the Coroner, renovations have been initiated in the Cook County morgue to rehabilitate the entire building into an Institute of Forensic Pathology for the coroner of Cook County. Appropriations by the county commissioners and an authorized bond issue have made $1 million available. The first phase in the renovation program has been started, and the final phase will be initiated in about two years when the new County Hospital Laboratories will have been built, thus releasing the entire morgue building to the coroner.

Edwin F. Hirsch
Chairman
Samuel A. Levinson
Dennis B. Dorsey
C. Paul White
Frederick C. Bauer, Jr.
Grant Johnson

SELECTIVE SERVICE COMMITTEE

Report not available at this time.

VETERAN'S ADMINISTRATION COMMITTEE

Report not available at this time.

TO: IPAC

There have been five meetings of the state medical advisory committee, and two more are planned—one on March 11 and the other on April 15. The dates of these meetings were June 25, August 20, October 8, December 10, and January 28. A change in the meeting time of this committee has been effected so that it now starts at 1 p.m., closing between 8 and 9 p.m., with dinner at 6. The meetings are scheduled for the Saturday before the Illinois State Medical Society Council meetings.

The attendance has been quite good, with as many as 12 to 15 being present at each of the meetings. The practice continues of inviting the county medical advisory committee chairmen as guests.

During the first five meetings a total of 16 resolutions and recommendations were referred to the state committee by the county medical advisory committees for special consideration.

A subcommittee was appointed to study and recommend changes in policy regarding physical therapy treatments for public assistance recipients. The recommendations of this subcommittee were studied by the state medical advisory committee during October, November, and up to its December 10 meeting, at which time the state committee recommended the adoption of new policy governing physical therapy. This new policy was adopted by the Illinois Public Aid Commission, to become effective Jan. 1, 1961. Physical therapy now can be started immediately and is given prior approval for the first two weeks by the county medical advisory committee. Approval beyond the first two weeks, up to three months, is given by the Division of Medical Services. Cases in which physician therapy is recommended for periods longer than three months are reviewed and approved by the state medical advisory committee. All accepted and currently used physical therapy modalities are approved in this program.

Recommendations for immunization against poliomyelitis were made by the state committee, and letters setting forth the recommendations of the committee were sent to the presidents and secretaries of all county medical societies in Illinois over the signatures of the chairmen of the state medical advisory committee and the chairman of the Poliomyelitis Control Committee of the Illinois State Medical Society.

Several county medical advisory committee resolutions and recommendations were submitted concerning the prescribing of drugs. As a result of studying numerous analyses of the variety and quantity of drugs which were being prescribed by a physician for a single recipient, the committee recognizes the importance of maintaining control of drug costs by supporting the Commission's present policies on prescription writing. Many expensive brand-name drugs are prescribed. In several cases referred to the state medical advisory committee for consideration the medicine costs as much as $1 per tablet. The problem of determining essential medical care still requires much deliberation and judgment by this committee.

The Cook County Medical Advisory Committee has recommended that consideration be given to the request that physicians in Cook County be paid for services to recipients in hospitals in Cook County. At the present time these services are given without remuneration.

Cost standards for laboratory procedures were reviewed, and some changes and additional tests were included in recommendations of the state committee later approved by the commission.

Problems in specific cases were referred to the state committee for review and recommendation. In the past five meetings these cases were divided as follows:

Fees for surgery	53
Approval of special drug requests	40
Hospital extension beyond six months	29
Prostheses and braces	6
Proprietary foods (Sustagen & Metrecal)	1
Hospital visits beyond present quantity and cost standards	2
Dental care and dentures	3
Surgical assistant's fees	3
Special anesthesia fees	3
Out-of-state medical care services	1
Consultation fees—special problems	1
Physical therapy approval	1

In several instances members of the state medical advisory committee have represented the

committee in various counties in studying specific problems that arose in those areas. Counties visited by representatives of the state committee were Piatt, Union, Alexander, Pulaski, and Madison.

During the five advisory committee meetings, hearings were held in the case of three physicians, and reports of unusual practices were heard on 24 different physicians throughout the state.

J. W. Compton
Chairman
B. E. Montgomery
H. V. Fine
L. N. Hamm
H. C. McGavran
J. H. Steinkamp
J. R. Schlereth
M. C. Beecher
W. Schowengerdt
F. A. Tworoger
W. H. Whiting

WOMAN'S AUXILIARY COMMITTEE

Report not available at this time.

Woman's Auxiliary President
Report not available at this time.

TO: ILLINOIS MEDICAL ASSISTANTS ASSOCIATION

The purpose of an advisory committee is that, if and when advice is sought, it should be intelligently thought out and given. An advisory committee should refrain from dictation, but certainly if it is apparent that the group which it serves is in error, it should be so advised. This has been the philosophy of this committee.

The Illinois Medical Assistants Association is a well balanced organization with very capable officers who take their responsibility to medicine and themselves very seriously.

The problems confronting the component societies have been well handled by local medical society advisory committees, and no problems have been brought to our attention nor have been presented to us by their officers except to individual committee members.

It is the opinion of the committee that this group of loyal allies to the medical profession should receive more support from the members of component societies. Only 15 counties are organized for assistants. There should be more. Many men express objections to the medical assistants groups that are not well founded; a review of their purposes and benefits to medicine should be encouraged at each county level. It is a deserving group which needs more stimulus from organized medicine.

Carl E. Clark
Chairman
S. Harry Bendes
Caesar Portes
Arkell M. Vaughn
Walter D. Stevenson

COMMITTEE ON AGING

During the past year the committee was primarily concerned with Illinois preparations for the White House Conference on Aging. Members of the committee, officers of the Illinois State Medical Society, and other physicians served on the Subject Committee on Physical and Mental Health. Dr. Roger Sondag served as co-chairman of this committee, Dr. H. Close Hesseltine as co-chairman of the Subcommittee on Financing Medical Care of the Aged, Dr. Edward Gordon as chairman of the Subcommittee on Changes Affecting the Health of the Aging, Dr. John C. Troxel as chairman of the Subcommittee on Health and Illness among Older People and Major Problems in Health of Older People, Dr. Ruth Church as vice-chairman of the Subcommittee on Health Services for Older People, and Dr. L. S. Greenwood as vice-chairman of the Subcommittee on Health Service in Illinois. Dr. Henry Ricketts served on the Research Committee. The Committee on Aging submitted a report stating in detail the position of Medicine and the activities of the Illinois State Medical Society in the field of aging. The report, used in preparation for the Illinois Conference for the White House Conference on Aging, was submitted to the White House Conference on Aging as part of the Illinois report. All members of the committee were appointed delegates to the state meeting in Springfield on September 6 and 7. Physician attendance and participation at the state meeting was excellent. The chairman attended all meetings of the Advisory Council on the improvement of the Economic and Social Status of Older People. This Council, established by the Illinois General Assembly and appointed by the Governor, was given the responsibility for the

Illinois preparations for the White House Conference on Aging.

Six members of the Committee on Aging were among the 100 Illinois residents appointed delegates to the White House Conference on Aging in Washington, January 9-12, 1961. In addition, twelve other Illinois physicians were named as Illinois delegates or as delegates from national organizations. Two members of the Women's Auxiliary of the Illinois State Medical Society also attended as delegates. Dr. George Lull and Mr. Roger White were appointed consultants to the Illinois delegation. A report on the White House Conference on Aging was submitted to the Council on Jan. 29, 1961, and a more detailed report has been forwarded to the officers, members of the Council, and each county medical society. Without exception, the physicians and members of the auxiliary who served as delegates to the Washington Conference attended all of their assigned meetings and participated in a most informed and helpful manner.

Two committee meetings were held during the past year. The committee met during the state meeting in Springfield on September 7, and those members attending the meeting in Washington met on Jan. 9, 1961. At both meetings future programs of the Committee on Aging were discussed.

The Committee on Aging cooperated in the preparation of the twelve-point statement on Policies and Programs on Health Care of the Aged, approved by the Council of the Illinois State Medical Society.

The Committee on Aging is planning an intensive Care of the Stroke program in cooperation with the Illinois Department of Public Health, the Illinois Public Aid Commission, the Illinois Heart Association, and the Chicago Heart Association. Dr. Edward Gordon is chairman of the subcommittee planning this statewide program, which will be held for physicians, nurses, and all others responsible for the care of the stroke patient. The committee is also sponsoring a program at the Annual Meeting on "Modern Concepts in Management of Strokes."

During the past year, the Illinois Joint Council to Improve the Health Care of the Aged held meetings on September 6 and March 16. Representatives from the Illinois State Medical Society to the Illinois Joint Council to Improve the Health Care of the Aged include Drs. Hesseltine, Mallory, Ricketts, Cannady, and Mr. Richards (Mr. White served as Mr. Richard's representative). The Illinois Joint Council is studying a proposed symposium on hospital, nursing home, and physician relationships. The Committee on Aging will cooperate in this program to facilitate at the local level the orderly transfer of patients between hospitals and nursing homes, to encourage the improvement of professional standards of nursing home care, and to assure the complete cooperation of physicians with the operators of approved nursing homes.

The Committee is continuing to prepare articles on aging for publication in the Illinois Medical Journal. Several articles have appeared during the past year and others are in the process of preparation.

The committee desires to acknowledge the invaluable services of Mr. Roger White, director of Medical Services and Economic Research of the Illinois State Medical Society, as consultant and for providing staff services throughout the year.

Edward W. Cannady
Chairman
P. V. Dilts
Edward E. Gordon
J. J. Kozma
Joseph Mallory
Caesar Portes
Henry T. Ricketts
Henry L. Schmitz
Roger F. Sondag
E. Lee Strohl
Thomas I. Tourlentes

AMERICAN MEDICAL EDUCATION FOUNDATION

At the suggestion of the American Medical Education Foundation headquarters, objectives in Illinois for carrying on the work of the AMEF promotion have been established.

1. Emphasize the value of AMEF contributions.
2. Sell the need of medical educations.
3. Provide opportunity for additional giving.

Illinois physicians not only have contributed by the allocation of dues but also have given an equal amount directly to medical schools

throughout the country. This particular phase establishes the fact that donations through our dues structure does not discourage physicians from contributing to their own schools.

The Council of the Illinois State Medical Society approved three committee requests:

1. That a letter be sent to all county medical society officers, together with a statement to be presented either to the society or to the hospital staff, or in some cases, at both levels.

2. That the Citations and the Awards of Merit presented to six Illinois physicians be handled by the member of the Council in the area where the physician resides.

3. That a state-wide mailing of AMEF brochures be made when it is possible without additional postage cost to the Society.

At the June meeting of the American Medical Association in Miami, a check in the amount of $170,890 was presented to Dr. George F. Lull as president of the AMEF. At the close of the calendar year, an additional check was sent to Dr. Lull in the amount of $12,635. Therefore, during 1960 the Illinois State Medical Society, through the allocation of $20.00 from each physician's dues, has given the AMEF a total of $183,525.

The Illinois State Medical Society has been an outstanding leader among all of the medical groups in contributing to the AMEF. Since 1955 we have given over $1.5 million to medical education.

The deans of all the nation's medical schools, and especially those in the Chicago area, appreciate greatly the outstanding response to the needs of medical education. They have come to depend upon the members of the Illinois State Medical Society as a very important group assisting them to meet the needs of medical education. As state chairman, I would like to stress the importance of this continued giving through the dues structure, and call the attention of the membership to the important role played by Illinois, especially during the past five years.

As state chairman, I have no specific requests from the House except to urge that the present method of contributing to the American Medical Education Foundation through the allocation of dues and voluntary contributions be continued in the future.

Arkell M. Vaughn
Chairman for Illinois

COMMITTEE TO ANNUAL MEETING PROGRAM

No report to be submitted.

CANCER COMMITTEE

The primary concern of the committee during the past year was the problem of how to bring the patient to the physician sooner for treatment.

Measures discussed to achieve this objective included programs to sharpen the physicians' diagnostic skills, the use of tumor registry systems, establishment of standards for laboratories used in the detection of cancer, and closer cooperation with national cancer programs.

Recommendation 1: That the establishment of periodic local cancer seminars, to be held at the request of hospitals, be encouraged as a means of improving the coordination of the study of cancer.

Recommendation 2: That ISMS encourage establishment of the principle of conducting tumor registries and encourage all hospitals to adopt registry systems.

Recommendation 3: That ISMS explore the possibility of establishing professional standards for clinical laboratories.

Recommendation 4: That ISMS endorse the annual three-day symposium of the American Cancer Society in Chicago, which is for physician education.

The intent of these recommendations is to effect the earliest possible accurate diagnosis of cancer so that the patient may be placed under the care of a physician as promptly as possible.

Caesar Portes
Chairman
Ruth Church
Warren H. Cole
Edwin F. Hirsch
Russell M. Jensen
F. J. Moore
Wilson R. Scott
Thomas Sellett
Augusta Webster

COMMITTEE ON CARDIOVASCULAR DISEASE

The Cardiovascular Disease Committee was appointed primarily to evaluate the work done in this field in the State of Illinois. Therefore, if we examine the work done by the Illinois and

Chicago Heart Associations, we will gain the best perspective into this total picture.

Since the Heart Association is a voluntary health agency it employs the efforts of hundreds of thousands of volunteer workers as well as a paid staff. This volunteer effort is in itself a very healthy arrangement.

Education is one of the main efforts carried forward by the Heart Association. The programs offered at periodic state conferences are attended by many physicians who hear papers written by outstanding men in the field. The St. Clair County Heart Association has established a lectureship in cardiology to be given each February to the local medical society. "Modern Concepts" is a periodical sent to each physician. It contains a great deal of information in all phases of cardiovascular subjects. The Heart Bulletin is another valuable publication. An educational program is also extended to the lay public in the form of films, pamphlets, and news releases.

In the field of rheumatic fever a great deal of work is being done. Both the Chicago Heart Association and the Illinois Heart Association, working through special committees, have been bringing the story of rheumatic fever to the public in the form of diagnostic clinics, conferences for nurses, and throat culture programs in many of the public schools. The most modern concepts of prevention of primary attacks of rheumatic fever and prevention of recurrent attacks have been brought to an ever increasing number of people in the state. An appropriation of money by the state legislature provides penicillin or sulfonamide for those unable to pay for these drugs used in prevention of recurrences.

Weight reduction programs have been carried out in many cities through the heart associations with the help of qualified dieticians.

Work classification units which function in the evaluation of patients with cardiac or vascular diseases have been set up in an attempt to get patients back to work at the proper job despite their disability. The Heart Association has worked closely with the Illinois Vocational Rehabilitation office in this service.

Through the help of an untold number of volunteers an annual drive is conducted to collect donations to the heart fund. Part of this money is retained locally to carry on programs in the cardiovascular field; the remainder is sent to the Illinois Heart, or Chicago Heart office, part to be retained and part to be sent to the National Heart office. The primary use to which this money is put is basic research into the causes and prevention of cardiovascular disease. Illinois Heart and Chicago Heart associations also have worked jointly in establishing a research program in this field.

This, then, is a brief summary of the work being carried on in the field of cardiovascular diseases in the State of Illinois.

Arnold S. Moe
Chairman
Wright Adams
Richard Dukes
Alva P. Nancy
Oglesby Paul

CONSTITUTION AND BYLAWS

As a result of the reorganization of the Illinois State Medical Society, certain additional changes in both the Constitution and Bylaws should be made.

At the time this report is being prepared, we do not have the suggested changes in form for publication. However, they will be ready for the members of the House prior to the annual May meeting and will be prepared in detail for consideration.

Changes will be presented dealing with various subjects.

1. It has been suggested that a change should be made in the dues structure to accommodate physicians not in private practice. This would include men in research, men in teaching, men employed by paramedical groups, and men in hospital service.

2. The Constitution should be changed so that the fiscal year of the Illinois State Medical Society coincides with the calendar year. This is a recommendation of our auditor and makes budgets much easier to develop since dues are collected on a calendar year basis.

3. We have received suggestions that the name of the Society be changed to "The Illinois Medical Society." "The Illinois State Medical Society" causes a great deal of confusion in some areas since the Society has no connection with the State of Illinois.

4. New members should be admitted by paying one-half year's dues after July 1; no other breakdown should be permitted. This should be stated specifically in the Constitution and Bylaws.

5. A policy should be established relative to the payment of dues to the Society by transfers to Illinois from other states.

6. The Constitution and Bylaws should eliminate the office of General Chairman of the Committee on Arrangements. This work has been absorbed by the Committee to Program the Annual Meeting.

7. Perhaps that portion of the Constitution and Bylaws which refers to standing committees should be revised in view of present and past committee activities.

The Committee on Constitution and Bylaws will have a supplementary report for the May meetings of the House which will be mimeographed and distributed in the packet for all delegates and alternates. This supplementary report will contain all of the changes requested by various committees and also those suggested by the committee itself.

Walter C. Bornemeier
Chairman
Andrew J. Brislen
Arthur F. Goodyear
Fred C. Endres
Ralph Redmond

ETHICAL RELATIONS COMMITTEE

Report not available at this time.

EYE HEALTH COMMITTEE

The first issue considered by the committee was drawing up a form for eye examination which would be suitable to both the ophthalmologist and optometrist.

This was made necessary by House Bill #30, which was enacted into law on June 30, 1959, and amended the School Code by making compulsory a vision examination of all children in the first, fifth, and ninth grades. The form for ocular examination, which the committee considered adequate, was developed by altering the form previously adopted by the Illinois Optometric Association.

The form was then given Council approval, as requested by the committee, and copies were sent to the superintendent of public instruction, the director of the Illinois State Department of Public Health, and the president of the Illinois Optometric Association. All of the above was accomplished in June.

In August, 1960, J. Robert Fitzgerald, M.D., requested that the use of the form be reconsidered on the basis that such an examination would of necessity have to be performed by either an ophthalmologist or optometrist and would, under these conditions, make it practically impossible for the general practitioner and pediatrician to complete the ocular examination.

Since the law failed to specify an eye examination and instead specified vision examination, Dr. Fitzgerald felt that the law will have been satisfied if only the visual acuity of the student is obtained at the time of the examination (visual acuity being only one portion of an eye examination).

It was further agreed by the committee that since the law requires that the vision examination be done by a licensed physician or licensed optometrist, all licensed physicians are eligible to perform the test.

It was agreed by the committee, however, that the form as approved by the Council shall continue to be the approved form for examination and be used by the ophthalmologist in reporting to the school those cases which have been referred to him by the licensed physician who feels that a more thorough ocular examination is in order.

The second issue considered by the committee concerned Resolution #51 passed by the House of Delegates of the American Medical Association at its June meeting concerning the medical aspects of contact lenses.

It was brought to the attention of the committee by A. G. Boeck, Jr., Director of Scientific Activities, that Joseph O'Neill, M.D., had suggested a plaque be provided by the Illinois State Medical Society to all members with the request that the same be displayed prominently in their respective offices.

This was discussed from all angles, namely, financial, public relations, and willingness or reluctance on the part of some practitioners to display the plaque; and it was generally agreed that before ophthalmologists could enlist the aid of their medical colleagues they had a duty to provide medical facts relative to contact lenses.

To initiate this educational campaign, an editorial covering the subject of contact lenses was published in the Journal in January with the recommendation to the Council that it be considered in lieu of the printing and distribution of a plaque to all members. It was further voted and approved that this be the beginning

of an eduetional program on the subjeet of contaet lenses.

M. Byron Weisbaum
Chairman
Peter C. Kronfeld
Frank C. Newell
Manuel L. Stillerman

FIFTY YEAR CLUB

The Fifty Year Club luncheon was held the first day of the state medieal meeting, at the Sherman Hotel, in May, 1960. One hundred and seventy members and guests of the club attended the luneheon. Our guest speaker was Dr. James H. Hutton. His talk was interesting and well reeeived.

Fourteen members of the Chicago Medieal Soeiety were indueted into the elub. Sinee it was organized in 1937, fifty-year certifieates have been issued to 1,450 members. As the old members drop off, new ones are added each year. We have approximately 510 to 515 living members. Our Fifty Year Club was first of its kind to be organized in the United States. Several states have since followed suit.

The 1961 luneheon will be held in the Assembly Room of the Hotel Sherman on Tuesday, May 16, beginning at 12:30 p.m. Our guest speaker will be Dr. Pereival Bailey of the University of Illinois Sehool of Medieine.

Andy Hall
Chairman
E. E. Davis
G. C. Otrich
William S. Bougher

COMMITTEE ON IMPARTIAL MEDICAL TESTIMONY

This report is one of progress. In October, 1959, Chief Judge Campbell of the United States Federal Court, Northern District of Illinois, and the judge in this area adopted Rule 20, utilizing impartial medieal witnesses from the panel list of the Illinois State Medieal Society. The judges of the federal eourt and the plaintiff-defendant attorneys have been favorably impressed and satisfied with the operation of Rule 20. Many cases were resolved at pretrial hearings; others were resolved before a ease went to trial, and an oecasional case was tried in court. The availability and use of the list of impartial medical witnesses, supplied by the executive office of the Soeiety, aided eonsiderably in speeding up many of the baeklog cases.

Sinee this program of impartial medical testimony was initially sponsored by the doetors of the Illinois State Medieal Soeiety, it was suggested that this or a similar program be made aecessible to the various eourts in the entire State. In June, 1960, your ehairman was invited to appear before the Judieial Conferenee of Cirenit and Superior Court Judges and the Judges of the Illinois Supreme Court at the Northwestern University College of Law. This conference recommended the adoption of a rule similar to Rule 20. The motion for adoption was referred to the Illinois Supreme Court. In the fall of 1960 three members of our eommittee were invited to meet with Chief Justice Walter V. Sehaefer, of the Illinois Supreme Court, to review this program. On Sept. 28, 1960, the Illinois Supreme Court approved the principle of impartial medical testimony and appointed four lawyers, including the general eounsel of the Illinois State Medieal Soeiety, Mr. Walter L. Oblinger, to prepare a rule for adoption by the court. Subsequently, on Nov. 11 the committee submitted to the Supreme Court of Illinois Rule 17-2, whieh embodies the prineiples of this program as recommended by the Committee on Impartial Medieal Testimony of the Illinois State Medieal Soeiety. Although the status of Rule 17-2 is still undecided at the date of this writing, it is antieipated that the Illinois Supreme Court will act on the rule during the Mareh, 1961 term of eourt.

Many meetings were held between the Committee on Impartial Medieal Testimony and the doctors eomprising the panel of medical experts, invited guests of the Chicago and Illinois Bar associations, the Ameriean Bar Assoeiation, the Ameriean Medieal Assoeiation, and ancillary groups. Although some opposition, which is to be expeeted, has been expressed by plaintiffs' attorneys, the importanee of impartial medical testimony and the value of the expert and eompetent opinions of the doctors on the panel is an invaluable step forward in the interests of justiee for all parties concerned.

The ehairman of this eommittee is most grateful to the members of the committee, the members of the Council and offieers of the Illinois State Medical Soeiety, the exeeutive administrator, and the excellent staff of doetors on the panel

list of impartial medical witnesses, whose integrity and medical and scientific competence is beyond question, for valuable aid and support.

S. A. Levinson
Chairman
Newton DuPuy
Percy E. Hopkins
Aaron Kanter
LeRoy Sloan
Norman Roberg
Wright Adams
Clinton Compere
Roland Mackay
Harold Voris
Ken Roper
V. P. Siegel
John Condon
Warren Young
Arthur F. Goodyear
Roger Harvey
Ex-officio:
H. Close Hesseltine
Edwin S. Hamilton
E. A. Piszczek

REPRESENTATIVES TO THE INTERPROFESSIONAL COUNCIL

The Interprofessional Council has been most active during the current year. Your representatives have been present at each of the Interprofessional Council meetings, scheduled on a monthly basis. These meetings have also been attended by our executive administrator, Mr. Robert L. Richards.

On February 28, Mr. John A. Doherty, executive secretary of the Michigan Health Council, discussed with the Interprofessional Council the activities of his organization. We discussed how this Council might sponsor the formation of an Illinois State Health Council. Many questions were asked of Mr. Doherty, and he provided much enlightening information.

The objectives of a state health council are (1) to aid in student recruitment; (2) to aid in programs for the placement of doctors in various health professions in communities having the greatest need for health care; (3) the organization of councils at the county level, and (4) to serve as an instrument for a much broader area of interprofessional relations.

Also present at the February 28 meeting was Mr. Ivan Parett, executive secretary of the Public Relations Committee of the Illinois Agricultural Association. Mr. Parett has always been interested in the solutions to health problems throughout the State of Illinois, and we appreciated his attendance and his interest.

The Interprofessional Council held a Christmas party in December and will sponsor an award dinner in March, when recognition will be given to an outstanding contributor to the health care of the people of Illinois.

Several inquiries have been received by the Interprofessional Council from a few national and county-level organizations about the functions of the Interprofessional Council. These inquiries have been answered and information provided. Invitations have been extended to attend the council meetings for further information and guidance.

Representatives of the Interprofessional Council expect to meet with Governor Kerner on March 10 to outline its purposes; a further report will be presented at a later time.

The Interprofessional Council sponsors a publication known as "Interprofessional Comments." It may be of interest to the medical profession to know that: (1) The American Dental Association has gone into its second century of activities, and (2) Loyola University's Chicago College of Dental Surgery has been opened.

The profession of podiatry has become most interested in the care of the aged. The portion submitted by the optometrists discussed the problem of "Space Myopia," which is presently being researched at Indiana University.

The Veterinary Association representative discussed the use of veterinary hospitals in national emergencies, and indicated that well equipped veterinary hospitals throughout the state could readily be converted and used as hospitals in case of emergency, with the veterinarians working under the supervision and direction of a physician.

Our representatives look forward with interest to further discussion with members of the Interprofessional Council, and plan to meet with them several times between now and May 14.

George B. Callahan
Chairman
A. J. Brislen
James D. Majarakis
Roland R. Cross
Carl E. Clark

Ex-officio:
Mr. Robert L. Richards
Mr. Walter L. Oblinger

LIAISON, ILLINOIS HOSPITAL ASSOCIATION

Liaison with the Illinois Hospital Association has been maintained throughout the year through our committee and a similarly constituted committee appointed by the hospital association. The joint committees held their initial meeting January 27, 1961, to review an agenda for the year as submitted by the hospital group and to begin its work.

The first item of the agenda concerned planning for the 1961 conference of hospital administrators, medical chiefs of staff, and board presidents. This is the third year for this meeting to be jointly sponsored by the hospital association and the state medical society. At the time of this writing, plans are under way to hold the meeting in Springfield, April 19, on the subject of hospital utilization. The program will include panel discussions, workshops, and a case study of the utilization control program in operation in the Tenth Councilor District of Pennsylvania. Two additional meetings of the joint liaison committees are scheduled before the annual meeting. Hospital infections will be discussed during March with the balance of the agenda to be discussed in April.

Some of the problems presented for discussion before this committee directly concern other committees of the Society. In those instances the committee acts in a referral capacity. It is felt that the establishment of these two parallel committees, with a planned agenda and definite schedule of meetings, will do much to improve communications between the medical and hospital groups.

John J. Procknow
Chairman
James B. Gillespie
Newton DuPuy
John L. Keeley
H. J. Shaughnessy
Ex-officio:
H. Close Hesseltine
E. A. Piszczek

LIAISON—ILLINOIS BAR ASSOCIATION

This report is one of progress. Numerous meetings of your committee have been held throughout the year resulting in a final draft of the Interprofessional Code for the Medical and Legal Professions. The purposes of this code is to establish standards of practice and ethical conduct for physicians and lawyers in those areas in civil cases where there is and will continue to be an interrelationship of medicine and law, and thereby improve the practical working relationships of the two professions; to protect the legitimate interests and rights of the patient-client, of the physician, the lawyer, and of society, and thereby to help advance the more effective administration of justice. The code constitutes recognition that the members of each profession have an obligation not only to the individual who obtain their advice and assistance but also to the community and society as a whole, and to all other members of their own respective professions. Your committee sincerely hopes that the code will be a valuable guide in the accomplishment of these purposes.

On Sunday, Jan. 29, 1961, the Council and officers of the Illinois State Medical Society met and considered a motion to adopt the Interprofessional Code. However, since the objectives of the code can be achieved only if the members of both professions acquaint themselves with these standards of practice and follow them, subject to rules of law and principles of medical and legal ethics, it was resolved to defer action on the code so as to provide the officers and Council members of the Society an opportunity to review and submit the code to the House.

The chairman of this committee is most grateful to the members of the Liaison Committee of the Illinois Bar Association, the officers and members of the Council of the Illinois State Medical Society, and the executive administrator for their valuable aid and support.

Newton DuPuy
Chairman
William E. Adams
Arthur F. Goodyear

MATERNAL WELFARE COMMITTEE

The committee recommends that the House of Delegates support the effort of the Committee for the Study of Obstetrical Hemorrhage of the Illinois Obstetrical and Gynecological Society in its effort to reduce maternal mortality from this cause. A similar committee is being formed for the voluntary registration of eclamptogenic toxemias in the state to provide data for which a program may be developed within the state

which will abolish death from this preventable disease. A third committee will soon be formed to attack the problem of deaths from puerperal sepsis.

The reasons for these are:

1. That the committee feels that a large percentage of these deaths are preventable if the information which has been gathered by the Maternal Welfare Committee can be properly disseminated to the members of our Society.

2. That these three causes head the list of causes of maternal deaths in Illinois.

3. That the members of these committees will receive added stimulus to their work by knowing that they have the support of the House of Delegates.

The reduction of maternal mortality has been very gratifying over the past 30 years; it has reached a plateau in the last few years. We are anxious to see further reduction, and we are sure it can be attained by the united efforts of the medical profession of the state.

The Maternal Welfare Committee held five meetings at the Palmer House and one in August at East St. Louis. The latter was attended by a representative of the Council and is the first of a series of meetings which will be held in various parts of the state to acquaint the councilors and members of our Society with the activities and objectives of the committee. The meeting was held at the home of one of the committee members, Dr. Willard C. Scrivner.

As in the past few years our committee has studied the deaths occurring at Cook County Hospital and has included these cases in our report. Dr. Augusta Webster, chief of the obstetrical staff of Cook County Hospital, has attended our Chicago meetings and helped with the discussion of these cases. The Cook County Hospital residents connected with these cases were present to help with their presentation and to benefit from the discussion. A member of the pathology department, Dr. Santo or his representative, presented the pathological report, and in many cases stereoscopic slides of the important pathologic findings were shown. This has improved appreciably the accuracy of the classification of the causes of death.

The total number of cases for 1960 was 85 as opposed to 79 for the previous year. All of the protocols and pathologic reports have not been available for study by the committee as yet, and therefore percentages of deaths which were preventable, or non-preventable, and the number of cases to be classified as obstetric or nonobstetric cannot be given at this time. The information will be presented in a supplementary report as soon as available.

The members of the committee actively participated in the Fifth Illinois Congress on Maternal and Infant Health, which was held in Springfield, February 8-10, 1961. An excellent program was prepared by a committee under the chairmanship of Dr. Joseph R. Christian, River Forest. Dr. John Payne, La Grange, was the general chairman of this congress.

Frederick H. Falls
Chairman
A. B. Owen
William J. Farley
Worling R. Young
Ralph R. Loar
Robert R. Hartman
J. B. Waller
Carl Greenstein
J. W. Tidwell
W. C. Scrivner
Nicholas Primiano

MEDICAL ECONOMICS COMMITTEE

The committee has devoted it's full attention to a single assignment from the Council during the year, that of exploring the merits of a Relative Value Study in Illinois. The national trend toward more third-party purveyors, including government programs with fixed fee levels, has focused renewed attention on the Relative Value Study.

Relative Value utilizes the principle that the fees charged for each medical procedure bear a constant relationship to each other regardless of variation by geographical area or type of practice. The Relative Value Study establishes this relationship according to the going rates. The findings thus compiled constitute a Relative Value Index or numerical expression of what each of some 1,900 procedures is worth in terms of the others.

The Relative Value Index is not a fee schedule. It is an authenticated base upon which a fee schedule or an indemnity schedule may be built by applying appropriate conversion factors to the index. It has application in grievance pro-

cedure, insurance review, and other third-party operations where a pricing mechanism is needed. It provides a base from which a physician's fees may be defended by his society or association. Eleven states have already formally adopted a Relative Value Index. Others use it for special purposes. It is used by Blue Shield plans in several states and by some insurance companies.

The question of Relative Value was placed before the 1960 Illinois House of Delegates last May. As a result of this discussion the Council was instructed to study the problem and to make recommendations to the 1961 House. The Committee on Medical Economics, in turn, received this assignment from the Council, and the question of whether or not a Relative Value Study should be conducted in Illinois is being explored.

As an initial step, the committee met on October 10 to hear a first-hand account of the history and development of Relative Value from the chairman of the AMA Committee on Medical Practices. At that time the committee also heard opinions from the purveyors of health services, both private and government financed, including (1) non-profit, (2) profit motivated, (3) public aid commissions and others. Plans have been set up to obtain further opinions from some 23 specialty societies throughout the state and to obtain grass-root opinions from the general membership by means of regional conferences.

Three regional conferences have been scheduled for March and April, one in Chicago and two downstate (Springfield and Harrisburg). Each regional conference will consist of a panel discussion by selected members of the committee bolstered by out-of-state medical experts who have had firsthand dealings with the development and use of Relative Value in their states. The regional conferences will be educational in nature, designed to feel out existing sentiment, not to promote opinion either for or against Relative Value. Each county society is being asked to send delegates to one of the three conferences —preferably delegates selected from among officers, members of the ISMS House of Delegates, and their prepayment plans and insurance committees.

In preparing for gathering these opinions, the committee has assembled substantial material on this subject, which it expects to present along with the results of its statewide survey, to ISMS delegates at the 1961 meeting. It is hoped that this will provide a basis upon which the delegates can appraise the situation and reach a decision.

C. Elliott Bell
Chairman
Walter C. Bornemeier
Max Sadove
Fred H. Decker
Franklin J. Moore
John C. Smith
Ex-officio
H. Close Hesseltine
E. A. Piszczek
J. E. Reisch

MEMBERSHIP COMMITTEE

The Membership Committee is a new committee established following the last meeting of the House of Delegates. It is composed of the five deans of the medical schools in Cook County, and Chairman Walter C. Bornemeier and Fred C. Endres of Peoria. This committee was organized to consider the problem of increasing the membership in the society. Since nearly all ethical physicians engaged in the private practice of medicine are already affiliated with their county, state and national medical associations, this necessitates entering a new field.

The AMA House of Delegates at the Washington Clinical Session made definite recommendations in regard to membership.

1. The medical societies should grant membership to physicians holding licenses in other states as well as to those physicians whose activities do not demand licensure.

2. Constitution and Bylaw provisions which restrict voting membership to private practitioners should be repealed along with any requirements imposing a long term residency.

3. Programs for scientific meetings should be re-evaluated so that medical society meetings will be of interest to nonpracticing as well as practicing physicians.

The increase in the number of physicians not in private practice assumes additional importance since an ever-increasing proportion of the medical care being provided is furnished by physicians not in private practice. The role of physicians employed by the government provides a good illustration of this fact. Physicians employed by the federal, state, and local

governments number about 10 per cent of the total physician count; yet this group is primarily responsible for the supervision of health and medical programs that account for an estimated 24 per cent of all public and private expenditures for health and medical care.

This committee has recommended that the Committee on Constitution and Bylaws consider establishing a new type membership for these physicians. Some of the physicians who are full-time teachers may be interested in affiliate membership with reduced dues. The committee asked that a careful consideration be made of this problem so that no interpretation of the action could result in considering this type membership as "second-class status."

The importance of an understanding on the part of the profession of the problem which confront full-time teachers was stressed. The necessity for supplementation of income through practice in the institutions in which they serve must be considered, and the institutions must be freed from the stigma of the corporate practice of medicine. The Iowa plan (one form of the "geographic full-time" system) was discussed by the committee in detail.

The understanding of the economic situation as it exists in the teaching field should be stressed. Since the problems which arise are not as serious in Illinois as they are in some of the other states, there is a real opportunity for this committee to develop cooperation and to provide an educational program which could exert an influence at the national level. The committee felt that this information should be given to the members of the House of Delegates of this Society, and that the delegates to the AMA House from Illinois might offer constructive assistance to the deans when the problems arise nationally. Cooperation in these matters at the national level exists now with the Council on Medical Education and Hospitals and the Council on Medical Service of the American Medical Association.

Perhaps this committee could invite newly licensed physicians to join with them for an evening meeting at some time during the year, or following examination and licensure. Activities of the society could be outlined, locations in Illinois where physicians are needed could be presented, and it might be possible to assist these physicians in a good many ways. If these newly licensed physicians felt they would benefit materially by joining their county society, they might automatically contact the local secretary when they enter practice. If the committee could ascertain the area in which the young men plan to practice, information could be forwarded to the officers of the country medical society involved.

It was also suggested to the Committee on Constitution and Bylaws that perhaps a "junior" membership could be offered for the first two or three years in which a man practices.

Walter C. Bornemeier
Chairman
Fred C. Endres
Lowell T. Coggeshall
Richard H. Young
John F. Sheehan
John J. Sheinin
Granville A. Bennett

COMMITTEE ON MENTAL HEALTH

The Committee on Mental Health had one stated meeting at the time of the American Medical Association Conference of Mental Health Representatives of State Medical Societies in Chicago. The Council on Mental Health of the AMA graciously invited the members of our committee to attend that meeting as they have done for the past several years. Four members were in attendance. Dr. Harry Phillips of East St. Louis served as chairman pro tem in the absence of the chairman.

The primary recommendation from the meeting was that the Illinois State Medical Society go along with the recommendation for the establishment of a state Department of Mental Health to care for the mentally ill and mentally retarded children. This recommendation was transmitted to the Council of the Society for action and was confirmed in principle.

In view of the attitude of Governor Kerner and of Dr. Francis J. Gerty. a member of the Illinois State Medical Society, as to the advisability of this, it is recommended that the House of Delegates concur in this recommendation of the committee and the Council. Many civic and professional organizations throughout the state have already taken action in this direction. It would place Illinois on a level of those states who have accepted the more advanced thinking on this problem.

Other items discussed at that meeting and for which recommendations were made included those made in previous reports from this committee, such as the continuance of interest on the part of the members, the Council, and the House of Delegates of the Illinois State Medical Society in the mental health program in general and the furtherance of community and mental health clinics in the hope of decentralizing some of the load now placed on our overcrowded state hospitals. The activity of the Academy of General Practice group was referred to, and it was recommended that representation of that group on the Committee on Mental Health be continued. Dr. H. D. Nesmith of Salem is active in that group and is a member of this committee. He has been most helpful in his contacts. Another recommendation was that Dr. Gerty as director of the Department of Public Welfare be asked to attend the meetings of the Council as was the former director, Dr. Otto Bettag. The Council concurred in this recommendation.

The committee took an active part in recommending to the Council the approval of the bond issue for the Department of Public Welfare hospital construction program. Also, a special committee, appointed by the Council, consisting of Dr. James H. Hutton, Dr. Leo P. A. Sweeney, and the chairman of the committe took part in the campaign.

The chairman of the committee served on the Emergency Committee of Fifty Thousand for the bond issue and spoke along with other members at various meetings over the state. He has been appointed on the Advisory Committee to the Department of Public Welfare and its new director and has attended meetings and participated in the activities. He has also addressed the Regional Conference on Mental Health of the American Academy of General Practice in Chicago at its meeting Feb. 5, 1961. The committee has approved the activities of the American Academy of General Practice in its educational program in mental health and it is hoped that the House of Delegates will concur in this approval. Most certainly, the program of postgraduate education is an active one. It is felt on general principles that closer liaison of the postgraduate education activities of the Illinois State Medical Society and of the American Academy of General Practice would be helpful to all concerned. After all, members of the Academy are also members of the Society. If they and other groups desire to embark on an educational program, organized medicine should not only commend the activity but should attempt to be a part of it.

Another recommendation of this committee is in regards to extension of information regarding certification under the Illinois Mental Health Code. Many physicians and some attorneys and county officials do not understand the various provisions. Dissemination of information through the Springfield Newsletter and/or Pulse would be helpful to all concerned.

Mike Gorman of the National Association of Mental Health wrote, "Every other hospital bed is occupied by a patient who is mentally ill." Most certainly, organized medicine needs to take part in any program that will alleviate overcrowding and enable outpatient and home care to be carried out and work towards the lessening of need for hospitalization by reason of active treatment being made available to these patients in the physician's offices and local services.

F. Garm Norbury
Chairman
Richard Graff
David M. Jordan
Harry LaPlante
John Madden
Harry Nesmith
Harry Phillips
John L. Reichert
Murray E. Rolens

Ad Hoc COMMITTEE ON KERR-MILLS BILL

With the passage of Public Law 86-778 (Kerr-Mills Bill) in October, 1960, the Ad Hoc Committee on the Kerr-Mills Bill was appointed to look into the problems of implementing this legislation in Illinois. The chairmen of other existing committees were selected because of their direct concern with the over-all problem of financing Health Care for the Aged. This involved the chairmen of the committees on aging, public relations, advisory to the Illinois Public Aid Commission and legislative, with the president and chairman of the Council serving as ex-officio members.

The committee first met on November 20, at which time representatives from the Illinois Dental Association, the Illinois Nursing Home Asso-

ciation, Illinois Hospital Association—all members of the Illinois Joint Council to Improve Care of the Aged—and the Illinois Public Aid Commission were invited to express their views and asked to cooperate in developing a program of medical assistance to the aged for Illinois (M.A.A.). All pertinent information about the new law was reviewed together with implementing legislation from Michigan, which at that time was the only state with a program in operation. It was decided that the best way to approach this was to prepare legislation which could be introduced in the Illinois General Assembly, convening in January.

After reviewing numerous drafts of suggested legislation, a final bill was developed which met with the committee's approval and which cleared up objections voiced by other members of the Joint Council on Aging. The bill was given approval by the Council on January 29. Discussion with IPAC officials indicated that further delays would be encountered before their studies of an appropriate plan would be completed. In view of the introduction of administration-sponsored national legislation to create a program under social security, it was decided that we should introduce Kerr-Mills legislation in Illinois without further delay. The committee held a conference with Governor Kerner on February 15 to acquaint him with the proposal.

On February 22 copies of the bill were sent to the officers and legislative chairmen of all county medical societies, and on March 1 it was introduced in the Illinois Senate by our legislative committee under sponsorship of Senator W. Russell Arrington and others.

The details of the bill have been distributed widely through other channels. By the time of the annual meeting the outcome of this particular bill will likely be known. Since the medical society has no control over what the Legislature may enact into law, it is difficult to predict what will eventually happen.

The proposal was carefully drafted to meet the objections of those who advocate a federal program under social security. If these principles are followed the program of medical assistance to the aged (M.A.A.—Kerr-Mills) will fulfill all the needs of the aged in Illinois for which government has a responsibility.

The committee wishes to thank all those who helped with this project, particularly the attorneys of the cooperating organizations and IPAC representatives. A special vote of thanks should go to the legislative committee, Mr. Walter Oblinger, and to Mr. Roger White of the staff.

E. W. Cannady
Chairman
R. J. Bennett
J. W. Compton
R. E. Heerens
Ex-officio:
H. Close Hesseltine
E. A. Piszczek

COMMITTEE ON NARCOTICS AND HAZARDOUS SUBSTANCES

While no formal meetings of the Committee on Narcotics and Hazardous Substances have been held up to the time of the early preparation of this report, it is probable that some legislation concerning narcotics or dangerous drugs, which will reqiure review by the committee, will be introduced in the current session of the Legislature.

Contact and informal liaison has been maintained by the chairman during the year with the State Division of Narcotics Control. It is apropos to note that no serious problems or difficulties have arisen concerning the medical use of narcotics according to the regulations imposed by the Narcotics Law and that narcotic addiction among the physicians of Illinois is probably now at a lower level than at any previous time.

The committee feels impelled to bring to the attention of the House of Delegates the information that the resolution it passed last year "disapproving ambulatory clinic plans for the treatment of narcotic addiction" was submitted "almost" verbatim by another state medical society to the AMA House of Delegates at the Clinical Session in Washington, D.C., November, 1960. This resolution was accepted by the AMA House of Delegates and referred to the Council on Mental Health.

If the work of this committee encompasses any major actions in the coming months, a supplemental report will be submitted.

Jacob E. Reisch
Chairman
Eli L. Borkon
George S. Schwerin
Earl H. Blair

COMMITTEE ON NURSING

Your committee has had two meetings and is contemplating a third in March.

The first was held Nov. 20, 1960, at which time the proposed changes in the Illinois Nurse Practice Act were discussed. The proposed change would permit graduates of the nursing programs in the junior colleges to take the examination and be licensed as a registered nurse after two years of the associate degree program, as established in the junior colleges in Illinois. The chairman was requested to attend a meeting of the Committee for the Associate Degree Programs in Nursing, sponsored by the Illinois League of Nursing, and report to the Committee on Nursing of the Illinois State Medical Society with the information obtained.

Also discussed, at the request of the president of the Illinois State Medical Society, was the request of the Illinois Hospital Association to consider the formation of an "Illinois Health Careers Council." After careful consideration of this proposal the Committee on Nursing met in joint session with the Public Relations Committee. The joint committee recommended to the Council that every effort be made by the Council to aid and assist county medical societies in arranging for "health fairs" at the local level to stimulate interest in the various allied health careers, and recommended that the Council reject the invitation to become associated in the proposed "Illinois Health Careers Council."

Your chairman attended a meeting of the Committee on the Associate Degree Programs in Nursing on December 7, and obtained some information on the proposed changes in the Illinois Nurse Practice Act as well as the proposed associate degree programs in nursing in the junior colleges of Illinois.

On January 21, the second meeting of the Committee on Nursing was held. Miss Freda Treptow, coordinator of nursing education, Department of Registration and Education of the State of Illinois, was present and presented information and replied to questions from members of the Committee on Nursing, concerning the proposed changes in the Illinois Nurse Practice Act, and its relation to the proposed associate degree program in nursing at the junior college level.

The Illinois State Medical Society through its House of Delegates has constantly advocated:

1. That the Illinois State Medical Society continue its efforts to solve the problem foremost in the concern of all physicians, the adequate provision of trained personnel to provide bedside care.

2. That the members of the Illinois State Medical Society, the Auxiliary and component societies continue to recruit individuals for the vacancies in training schools and other paramedical careers.

3. That the recommendation made in 1959 and again in 1960, that the Council of the Illinois State Medical Society consider and possibly assist in the presentation of a bill to establish the present three year hospital schools of nursing as three-year colleges of professional nursing, so that the individual student may transfer three years credit to the college of his or her choice to complete study and receive a Bachelor of Nursing degree.

Therefore, the following principles must be considered in any recommendation made to the Council and to the House of Delegates:

1. That an adequate number of professionally trained personnel be available for the bedside care of the individual patient.

2. That the proposed changes in the Illinois Nurse Practice Act does not bring about:
   a. Deterioration in the quality of bedside nursing care.
   b. Prove to be a deterrent to the present diploma and degree schools.
   c. Through its implications of college education, produce a decrease in the number of applicants for training in either diploma or degree schools.
   d. Act as a detriment to those areas where junior colleges are not established, or compete with training schools established in that same area.
   e. Complete and total divorcement of nursing education from the hospital and from the only qualified and adequately trained instructors, the medical profession.

3. That a definite coordination of the field of nursing education be established so that the apparent differences existing between the two, three, and four year programs be eliminated.

4. That graduates of either the two or three year program be permitted to continue their ed-

ucation, if they desire, toward a degree or degrees without any loss of time or credit on the basis of the school attended.

The meeting in March will be a further discussion of the proposed changes in the Illinois Nurse Practice Act, as well as the implications of the nursing program of the junior colleges of Illinois, with the members of the Committee on the Associate Degree Program of the junior colleges of Illinois as sponsored by the Illinois League for Nursing.

The committee also has a request from the president of the Illinois State Medical Society to discuss and make a recommendation to the Council and the House of Delegates of the Illinois State Medical Society concerning the proposed fund raising campaign by the American Nurses Foundation, for research in the field of nursing.

W. H. Schowengerdt
Chairman
Maurice M. Hoeltgen
Paul P. Youngberg
Willard Scrivner
Arthur F. Goodyear
J. O. Firth
Mary Louise Newman
Newton DuPuy
William K. Ford
Ted LeBoy
Angelo Creticos
Lorin D. Wittaker

NUTRITION COMMITTEE

The Committee on Nutrition is pleased to report the completion of one of its most successful years. In addition to contributions to the profession's understanding of nutritional problems, it was able to provide several services to the general public.

Highlight of the year was the annual Joint Conference on Nutrition, sponsored with the Illinois Nutrition Committee at Illinois State Normal University on October 8. The program, entitled "Nutrition Problems of the Family," attracted some two hundred physicians, educators, home economists, nurses, and others concerned with nutrition.

The following program was presented at the conference:

Introduction by H. Close Hesseltine, M.D., president, Illinois State Medical Society

"Prenatal Nutrition and Maternal Health," William J. McGanity, M.D., professor and chairman of ob-gyn, University of Texas at Galveston

"Infant Feeding: Current Concepts and Clinical Application," Herman F. Meyer, M.D., associate professor of medicine, Northwestern University Medical School

"Dr. Tom Spies, Pioneer Medical Nutritionist," James R. Wilson, M.D., former secretary, Council on Foods, AMA

"Advertising's Impact on the American Diet," Philip L. White, Ph.D., secretary, Council on Foods and Nutrition, AMA

"The Geriatric Patient," George C. Turnbull, M.D., associate professor of medicine, Northwestern University Medical School

Panel: "Nutrition Problems in the Working Years," Blanche E. Lenning, home economics consultant, Illinois Public Aid Commission, moderator

As is the custom with these conferences, the local county medical society (McLean County, in this case) served as co-sponsor.

In December, 1960, the committee was called in as a consulting agency by Dr. Lee Fatherree, director of the Illinois Department of Public Health, to evaluate the 900 calorie weight control formulas which had become so popular with the public.

The Committee prepared a report listing a series of precautions to be observed in avoiding the pitfalls of unsupervised reducing diets. A news release based on this report was widely used by newspapers and resulted in a special television and radio interview with the president of ISMS and the chairman of this committee on the subject. The report itself was published in the Illinois Medical Journal in February.

The chairman of the committee was also privileged to speak on "The Role of Nutrition in the Reduction of Perinatal Casualties" at the Fifth Illinois Congress of the American Association for Maternal and Infant Health in Springfield on February 8.

Although there is no Section on Nutrition to provide for a program at the annual meeting of ISMS, we were able to cooperate with the Section on Public Health and Preventive Medicine in scheduling a nutrition topic on its program.

In retrospect, the real significance of our activities lies in the manner in which the profes-

sion and the public alike have openly accepted nutritional subjects. Nutrition is a basic factor in human health, and if we have contributed to the appreciation of this, our efforts have been worth while.

Paul A. Dailey
Chairman
Harry Mantz
Warner H. Newcomb
G. C. Otrich
W. I. Taylor
Felix A. Tornabene
James R. Wilson

COMMITTEE ON OCCUPATIONAL HEALTH

We have received, considered, and approved in principle the revised Guide for Occupational Health Programs and have encouraged employment for the physically handicapped as suggested by the Committee on Occupational Health of the American Medical Association.

We have received, reviewed, and approved in principle the "scope, objectives and functions of occupational health programs" as presented by the representatives from the American Medical Association House of Delegates at the 109th Meeting.

At a combined meeting of the committees on industrial health of the Illinois State Medical Society and the Chicago Medical Society on Sept. 20, 1960, several problems were considered. At this meeting there were also representatives of the bar, Chicago Heart Association, American Heart Association, insurance carriers, Society for the Physically Handicapped, Chicago Society of Industrial Medicine and Surgery, and other related organizations interested in the Workmen's Compensation Act of Illinois. The conclusions reached at this meeting were to carry on the study and be guided in our activities by the findings. The study is continuing.

Your chairman attended the 20th Annual Congress on Industrial Health in Charlotte, N. C., Oct. 10, 1960. The value of the meeting to state representatives came under considerable discussion because, as guests of the Council on Occupational Health of the American Medical Association, they were not allowed active participation in the meetings. Less than half of the fifty states were represented.

Programs were well presented on occupational health programs, ionizing radiation, mental and emotional health, professional relations, acute trauma, dermatitis, etc.

For full coverage of the health program in industry as outlined at the meeting, it would be necessary to have a representative of each medical society (1) run a complete survey of every industry in each city and county of the entire state to determine their needs; (2) take a complete survey of all doctors to see if they are interested in and would take an active part in an industrial program; (3) coordinate the needs of those willing and briefed to serve.

The full Committee on Occupational Health met on Oct. 18, 1960. It was agreed that further study of the Workmen's Compensation Act would be reviewed even beyond the medical point of view so that several interests involved could be coordinated.

Efforts have been made to secure an outstanding medical director for the Industrial Commission.

Richard J. Bennett
Chairman
B. Dixon Holland
Milton H. Kronenberg
Arthur Petersen
O. W. Rest
V. P. Siegel
Clarence F. Kelly
Eugene L. Walsh
Fred Stansbury

PERMANENT HOME COMMITTEE

At the third session of the meeting of the House of Delegates last May, Dr. Ernest Breed, a member of the Council of the Illinois State Medical Society for the Third District, asked to have the privilege of the floor to discuss the matter of a permanent home for both Chicago Medical Society and Illinois State Medical Society. The whole matter is presented in the report of the session in the Illinois Medical Journal for the month of September, pages 203 and 204. The gist of the whole proposition is that Dr. Breed suggested that Chicago Medical Society was interested in buying a building in the West Side Medical Center, converting this building into office space, and inviting the Illinois State Medical Society to become a tenant in that building, at a certain fee per square foot, as would be arrived at, but which would entail no financial obligation on the Illinois State Medical Society.

This building would be known as the Medical Society's Building. The CMS had such a building in mind. It was available for purchase. They felt they could finance the whole proposition and simply request that we give some indication that we would be interested in occupying such a building with them.

Without going into further detail, which is well narrated in the pages of the September issue of our Journal, a motion was made. After some discussion by Dr. Harry Mantz, Dr. Paul White, and Dr. G. Henry Mundt, this matter was brought to a fruition, by a motion by Dr. Harry Mantz, delegate from Madison County, who moved after some explanatory discussion: "Mr. President, I think that the planning should start now, and therefore move that the president of the Illinois State Medical Society appoint a committee sometime in the near future to consider this proposition."

It was not suggested in the motion as to whom the committee would report, whether to the House of Delegates, or to the Council; but early in June a committee consisting of Dr. Harry Mantz, Dr. Arthur Goodyear, of Decatur, and me as chairman, was appointed to look into this matter. We had several informal meetings among ourselves. We talked to Dr. Breed about the proposition, and at the AMA Interim meeting in Washington we met and decided on a date when we, along with members of the Chicago Medical Society, could look this building over and come to a decision, then make a report to the Council at the meeting on December 9.

This plan was carried out. We considered the fact that a building such as this would not be ready for four or five years; that we would be offered space in this building for about half of what we were paying for our quarters at 360 North Michigan; that undoubtedly at the end of the present lease of our downtown headquarters our rent would necessarily be raised due to the contemplated tax situation in Cook County, and the time would be admirable for the Illinois State Medical Society to change from one building to another. Your committee decided to support this proposition submitted by the Chicago Medical Society and so informed the Council at the December 9 meeting as reported in the January issue of the Illinois Medical Journal. The Chairman submitted the report to the Council. It was approved, and we so notified the Chicago Medical Society. At the present time this is as far as the matter has gone. My plan in submitting this report to our executive administrator is so that it may be published in the Handbook and commented upon from the floor or referred to the Reference Committee in the coming May, 1961, meeting of the Illinois State Medical Society.

Joseph T. O'Neill
Chairman
Arthur Goodyear
Harry Mantz

COMMITTEE ON PHYSICALLY HANDICAPPED CHILDREN

When this committee was organized by esteemed pioneers in orthopedic surgery, it was limited to orthopedically handicapped children and adults. It embraced deformities and disabilities which followed as a result of injuries or disease of the musculoskeletal system. Because of the implied onus of the term "crippled children," the name was changed to the Physically Handicapped Children. Since then this term has opened the gates to other types of disability.

Mr. Walter Oblinger, general counsel for the Illinois State Medical Society, was contacted by Mr. Nathan Kaplan, representative in the General Assembly. He made inquiry as to what our attitude would be, should he offer an amendment to the act which created the State Commission on Physically Handicapped Children. He desires to amend the section dealing with the diagnosis and treatment. It would include those afflicted with intractible asthma and many other nonorthopedic disabilities. Should this be done, where would these do-gooder ideas cease?

The present care of the crippled child is more prompt and more efficient than ever before. Well trained and board qualified orthopedic surgeons are doing excellent orthopedic service, not only surgical but also convalescent care, in almost every sizable town or city in Illinois. The majority of these surgeons attend and take part in numerous orthopedic sessions during the year.

Notwithstanding the fact that the orthopedic profession has made great strides in the past, and is ever striving to improve, the members look forward to further betterment with confidence.

The following table summarizes the care of handicapped children during the past year:

RESUME OF HANDICAPPED CHILDREN SEEN AT CLINICS

Institution and Type of Clinic	Total Attendance	No. of Clinics	Av. per Clinic	Remarks
Montgomery Ward at N. U. Med. School				3 clinics weekly with av. of 2 children per clinic
Ill. Elks Assn. for Crippled Children	2,004	57	35.10	Physical & occupational therapy treat. under direction of referring physician. Therapists not permitted remuneration for services or equip. furn. patients.
Shriner's Hosp. for Crippled Children		100	37	Mostly orthopedically handicapped children
Children's Memorial		104	60 to 75	
Univ. of Ill. Div. of Services for Crippled Children				Clinics held from 1-1-60 to 12-31-60.
General orthopedic	10,086	204	49.44	
Cerebral palsy	338	22	15.36	
Cardiac	791	41	19.29	
Total	11,215	267	42.00	
Univ. of Chicago Div. of Orthopedic Surgery				Handicapped children seen at random in reg. daily outpatient clinics along with adults. No specific data kept.
Babette & Emanuel Mandel Clinic-Michael Reese				
Orthopedic clinics		2 weekly	11.1	
Cerebral palsy clinics		1 weekly	9.4	
Mt. Sinai Hosp.				This no. will probably increase when clinic becomes better known, as it was started in April, 1960.
Orthopedic clinic		2 weekly	3	
Cerebral palsy		1 weekly	1	
Pediatric-cardiac		1 weekly	5 to 7	
Cook County Hosp.-Fantus Clinic				
Orthopedic clinics		4 weekly	17.63	
Pediatric cardiac		2 weekly	28.72	
Central Free Dispensary				
Orthopedic clinics		2	3	

Frank G. Murphy
Chairman

James J. Callahan
Hugh Cooper
John Fahey
Ralph Kunstadter
Edward F. Lis
Arthur A. Rodriquez

COMMITTEE ON POLIOMYELITIS CONTROL

Since polio control has been temporarily stabilized by the increasing acceptance and use of Salk vaccine, your committee has not found it necessary to hold any formal meetings in the past year. Instead, personal consultations between members have occurred from time to time.

The official activities of the committee have been limited in the past year to answering requests for information and advice. Of these, the two of general interest are:

1. An opinion regarding the giving of vaccine, without compensation, to families in the IPAC program. IPAC provides payment for essential medical care only and does not include provision for preventive medical services. This agency has therefore advised that it cannot pay physicians for giving polio vaccine. The committee recommended that Illinois physicians cooperate in every way in the giving of polio vaccine without regard to compensation, but that the IPAC be consulted as to correcting this inequitable situation.
2. The committee was asked by the Council to review an outline received from the National Foundation outlining its "broadened chapter patient aid program." This pamphlet was sent to the Council for its approval. After reviewing the program as outlined, the committee recommended that the pamphlet be received and placed on file.

Both of these recommendations were approved by the Council.

The members of the committee are keeping in close touch with the developments in oral live vaccine, which is expected to be approved by the Federal Government and placed in use relatively soon. No action is indicated at present.

It is the suggestion of the chairman of the committee that the Committee on Poliomyelitis Control along with other committees in this area, in which only occasional or sporadic activity is necessary, be included in a committee on preventive medicine and public health. This would coordinate work in this area, lead to greater efficiency, and require less time from members of the Society and less duplication of effort on the part of the staff.

John Lester Reichert, *Chairman*
John B. Hall
James A. Conner
Fred Long
Joseph T. O'Neill

COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION AND SCIENTIFIC SERVICE

The number of requests for postgraduate conferences remained at a very low level last year and considerable difficulty was encountered in handling the few that did come in. The following recommendations are made as a means of solving the two problems:

RECOMMENDATION 1: That the Committee on Postgraduate Medical Education meet with representatives of other organizations which sponsor postgraduate conferences to evaluate the program on a state-wide basis. This would be to judge the adequacy of the total postgraduate medical education effort within the state and to delineate areas of responsibility among those conducting these programs. Ultimately we need direction regarding who is best qualified to conduct these programs.

RECOMMENDATION 2: That the structure of the Committee on Postgraduate Medical Education and Scientific Service be changed to enable it to handle requests for postgraduate conferences more efficiently. This would mean appointing to the committee one member from each of the five Chicago medical schools and three downstate members. As requests for conferences arrive, they would be assigned to one of the medical school representatives on the committee who would proceed to recruit the faculty for the specific program requested. This would provide close, professional liaison between the host county society and the school actually programming the conference. The downstate members would provide a balance of viewpoints during the planning and evaluating meetings of the committee. Once the program was in order, the Society staff would implement the details of publicity, expenses, and the like.

RECOMMENDATION 3: That the scientific speakers' bureau be overhauled to revitalize the program, update membership, and expedite service to component societies. That, because of the long distance between Chicago and some downstate areas, satellite speakers bureaus be established in Springfield, Rock Island-Moline, and Champaign-Urbana, to make speakers more accessible to outlying counties. This would conserve the travel time of speakers and reduce transportation costs in many cases.

In the period April, 1960, to February, 1961, the following 42 counties were served: Bureau, DeKalb, Champaign, Du Page, Greene, Henry, Jackson, Kankakee, Knox, La Salle, Lee, Macoupin, Montgomery, McDonough, McHenry, Peoria, Sangamon, Stephenson, Vermilion, Whiteside, and Winnebago. The Englewood Branch and the Stock Yards Branch of the Chicago Medical Society were also served. In doing so, 2,936 double postcards and 245 single postcards were mailed, and 166 news releases were distributed.

In the middle of the year the Council approved the transfer of the lay speakers bureau to the Committee on Public Relations. Up to this time speakers had been provided for 33 groups, which included the PTA, women's clubs, high schools, Golden Age clubs, young adult organizations, diet clubs, nurses groups, and woman's auxiliaries. Subjects requested were "The Importance of a Yearly Physical," "When to Call the Doctor," "Health of the Executive," "Health Security for our Senior Citizens," and a variety of topics involving mental health and nutrition.

With the establishment of a full time Public Relations Department in July, 1960, the radio program activity was transferred to it.

Although not completed at the time this report was prepared, there were three postgraduate conferences in process. These were for Marion, Lincoln and Charleston.

The committee was grieved by the death of its former co-chairman and long time member, Dr. George Kirby, and will miss his counsel and contributions to its activities.

Louis R. Limarzi
Chairman
J. H. Maloney
Julius M. Kowalski
Gilbert Marquardt
Charles D. Krause
N. C. Barwasser
Emmet F. Pearson
Paul A. Dailey
Max Hirschfelder
William H. Schowengerdt
Frank P. Skaggs
William Borgsmiller
I. E. Bartlett

COMMITTEE TO STUDY POSTGRADUATE MEDICAL EDUCATION

Before making an intensive study of the postgraduate medical education program in Illinois, the committee suggested that the programs in Michigan, Boston, and Florida be studied.

The Executive Committee recommended that these out-of-state programs be investigated by letter and phone as thoroughly as possible to determine whether visitations are warranted in terms of possible benefit to the committee.

Accordingly information is being compiled on the conduct and success of these three programs. When this has been accomplished, the committee will proceed to analyze the situation in Illinois.

Joseph T. O'Neill
Chairman
Louis R. Limarzi
V. P. Siegel
Ex-Officio:
Mr. Robert L. Richards
Mr. Donald L. Martin

COMMITTEE ON RADIATION

Dr. Roger Harvey submitted his resignation as chairman of the committee to the Council on Oct. 9, 1960. The Council accepted Dr. Harvey's resignation and appointed Dr. Carl Clark to succeed him.

The new chairman called a meeting on Jan. 28, 1961, to discuss the objectives and purposes of the committee as a means of outlining future activities. To assist in the discussion of the program for the Committee on Radiation, Dr. Lee Fatherree, director of the department of public health, and Clarence Klassen, who directs the radiation program for the department, were invited to attend as guests and resource persons.

After discussing the problems of radiation and radioactivity in the State of Illinois, and the activity currently sponsored by the state in the area of monitoring and inspection, it was emphatically decided that there was a definite need for a committee on radiation and that such a committee could be very valuable to the Society and the citizens of the state. Both Dr. Fatherree and Mr. Klassen stressed the need to have liaison with the practicing physicians in the state on the subject of radiation and the laws pertaining to it, particularly those involving registry requirements.

After thorough discussion, the following six

points were enumerated as principal areas of activity for the Committee on Radiation for the coming year:

1. A program to persuade physicians not to sponsor independent x-ray laboratories and not to send patients to unapproved laboratories for x-rays.
2. The promotion of the registry of all x-ray equipment.
3. The explanation of the state program in radiation safety and the endorsement of this program.
4. The improvement of standards of commercial x-ray laboratories.
5. Use of the Radiation Committee by all Illinois physicians as a means of presenting complaints and suggestions to the state department of public health.
6. Presentation of informative and pertinent articles to the Illinois Medical Journal on these and other aspects of radiation.

With these items clearly enunciated as a guide to the committee in the future, it is now expected that the committee can be active and render a real service in the future.

Carl E. Clark
Chairman
Earl Barth
J. A. Crilly
Fred H. Decker
Robert Landauer
Willard C. Smullen
Harvey White

COMMITTEE ON RURAL HEALTH AND STUDENT LOAN FUND

As it has during the past many years, the committee has cooperated with the health improvement associations in Illinois in an effort to enlist all possible people into the voluntary health insurance movement.

Beginning this year the Illinois Agricultural Association is offering Farm Bureau members the opportunity of buying its individual catastrophic medical care insurance. Only time will tell what effect this move will have upon the local county health improvement associations. The contributions, healthwise, to our rural people by the activities of their county health improvement associations have been too numerous to mention.

Dr. Jack Gibbs, one of the original participants in our Student Loan Fund Program, represented our Society at the Rural Health Conference in Grand Rapids, Mich., last year. He did an extremely commendable job, and his address was reported in a recent issue of the Illinois Medical Journal. He represented our state at the Rural Health Conference, sponsored by the American Medical Association in Chicago, in February.

With the joint efforts of the Society and the Illinois Agricultural Association the farmer-doctor student loan fund has reached the stage where it can be of revolving character, and we see no need to request from the Society any additional funds for the operation of this program beyond those already committed to current loans.

The student loan fund program entails the expenditure of much time and effort on the part of the committee. There are satisfactions, and tremendous disappointments in its operation. Early in February, we interview from 30 to 40 applicants for the 10 recommended spots in University of Illinois freshman class. The committee is extremely sorry that they have picked some young people who have not turned out well. Character, honesty, and integrity are just lacking in some people; and after many years of trying to appraise it, we have a few miserable failures. Another observation that defies explanation is that within a few months or a year after we give a young man in great need a loan, he marries and starts a family, although he didn't have enough on which to go to medical school when we loaned him the money. How people under this kind of pressure can end up being true physicians baffles the imagination.

A most interesting development has been the adoption of the student loan fund program by county, district, and city medical societies in sponsoring and loaning a student enough funds from local sources to assure his education with the proviso that he return to practice in his home town. An extension of this type of program may be the most beneficial result of the farmer-doctor loan fund program.

The House of Delegates of the American Medical Association at its Washington meeting directed the AMA trustees, in cooperation with the American Bankers Association, to sponsor and push the local aspect of loaning money for med-

ical education purposes. The Illinois Agricultural Association, the Illinois State Medical Society, Student Loan Fund Committee, out of their experience, certainly supported this action.

Our Committee would be derelict in its duty if we did not thank the Secretary, Mr. Ivan Parett of the Illinois Agricultural Association, for his conscientious and detailed work in the day-to-day management of our loan program.

Jack Gibbs
E. S. Hamilton
Harlan English

SUPPLEMENTAL REPORT RURAL HEALTH CONFERENCE

The third National Rural Health Study Conference was held on February 3 and 4, 1961, at the Palmer House, Chicago.

An interesting and informative panel on "Today's Health Dollar" opened the program. Although it is recognized that medical care costs have risen markedly, it was pointed out that they have not risen in proportion to other goods, services, and wages.

It takes 35 to 55 per cent less working time to purchase the same amount of medical or surgical care as it did in 1939. This, however, is not true of hospital care, which today requires 22 per cent more working time to pay for a like period of hospitalization. This is to some extent offset by the fact that time spent in the hospital for a given illness is considerably less than in times past, and this is a result of improved quality of medical and surgical care.

It was brought out in the discussion that the statistics on health care fail to point out that millions of medical care dollars go for food fads, patent medicine, and sheer quackery and that it is the responsibility of medicine and other related groups to further health education and information in these areas. In summary, it was felt that much of the hue and cry concerning present day medical costs was due to a diminishing spirit of self reliance in our society.

An excellent panel on "Changing Patterns of Medical Care" brought out the inescapable fact that there is some form of socialized medicine in every country in the world except those of North America. It was pointed out that many of these countries have neither the facilities, personnel, nor resources necessary for any type of medicine other than government-sponsored. Many newly developing countries, such as African nations will, of necessity, have government programs. It would seem that this trend elsewhere would not apply in our country which, through a system built on medical freedom and personal responsibility, has developed the highest quality of medical care in the world today. The differences and disadvantages of Britain's Health Service as compared to America's was clearly outlined by a British physician who has practiced under both systems. He outlined the good and bad points of the British Health Services as seen by the patient, the physician, and the politician. From every group there is some pressure for an increase in private practice and a decrease in governmental regulation of health care.

On the final day of the conference Dr. Clarke Wescoe, chancellor of the University of Kansas, discussed the role of the medical school in rural medical care and outlined his school's efforts in this regard. These include preceptorships with general practitioners as part of the senior curriculum, general practice residency in the hospital, and university-sponsored teaching programs held in various sections of the state. It was felt that these efforts were to a great extent solving the physician distribution problem in Kansas. It was pointed out that not every small town could support a physician and that people in rural communities should direct their efforts to development of medical facilities in areas which could support a physician and could be reached by surrounding small towns and country populace within a reasonable length of time. Also with the present over-utilization of physicians it was felt that group practices should be encouraged to relieve the burden of tremendous pressure on one physician.

Also speaking on this panel were the wife of an intern and a medical student. Neither of them, it turned out, plan to go into general practice nor to practice in a rural community, a depressing fact for the rural delegations at the meeting, I am sure.

It would seem that although these meetings are interesting and informative, they are singularly lacking in presentation of specific problems by the grass roots rural people attending the conference. It is difficult to see how rural areas are benefited unless specific conclusions are reached, followed by positive recommendations

and action through the AMA and its advisory groups of the Rural Health Council.

J. L. Gibbs

COMMITTEE ON SCHOOL HEALTH

One of the primary considerations of the Committee on School Health is accident prevention among school-age children. Toward this end, the committee reviewed the published reports of the 1961 White House Conference on Children and Youth and wholeheartedly endorsed the statement on body-contact sports in elementary and junior high schools. Because of its concern for the welfare of school-age children the committee submits the following recommendations:

Recommendation 1. That the Illinois State Medical Society endorse Section 7-8 of the Illinois Committee for the 1961 White House Conference on Children and Youth as follows:

7. Schools should not include body-contact sports, particularly tackle football and boxing, for children of school age through the ninth grade. Developmental needs of elementary school children are best met if physical activities are informal and not highly competitive. Children of elementary school age are particularly susceptible to bone and joint injury. Adequate medical supervision of all school athletic programs is essential.
8. Agencies sponsoring athletic activities outside of school programs should be required to provide for competent medical supervision.

Recommendation 2. That each physician in the State of Illinois acknowledge his obligation to the promotion of the improvement of school health programs, and that he accept responsibility for participation in such programs insofar as is practicable in his individual case. The ultimate success of any school health program will depend upon the active participation of the medical profession.

In reply to a query from the Public Relations Committee of the ISMS, the Committee on School Health indicated a willingness to cooperate with the PR Committee in considering the production of educational athletic injury clinics within the state. It was felt that until such time as body-contact sports in the elementary and junior high schools could be eliminated, the medical profession has an obligation to give all possible advice on how to manage such programs with a minimum hazard to the children involved.

With the increasing number of children enrolled in schools the problem of accident prevention and good health maintenance becomes ever more important, and the function of the Committee on School Health will increase in importance along with it. It is felt that the adoption and implementation of the above recommendations would greatly aid in the overall program to guard the well-being of these children.

W. W. Fullerton
Chairman
Richard E. Dukes
Ralph Kunstadter
Kenneth S. Nolan
John Lester Reichert
Arthur L. Shafton

COMMITTEE ON THE SPRINGFIELD OFFICE

Report not available at this time.

COMMITTEE ON TRAFFIC SAFETY

The Committee on Traffic Safety is pleased to report the completion of "phases one and two" of the Illinois-Cornell Automotive Crash Injury Research Project and the initiation of "phase three."

The committee urges the continued support of the physicians of Illinois on this project and especially wishes to convey its appreciation to the physicians and county medical societies that have participated in this project.

The Crash Injury Project was first approved by the Council on July 26, 1959. The Interstate Automotive Crash Injury Research data-collecting system coordinated by Cornell University is co-sponsored by the Illinois State Highway Police, Illinois Department of Public Health, Illinois Hospital Association, and Illinois State Medical Society. The purpose of the program is to obtain reliable data on the frequency, nature, and specific causes of injury to occupants of passenger cars involved in automobile accidents. This data will serve as a basis for automotive design changes aimed specifically at reducing the number of accidents and severity of injuries.

The following counties assisted in "phase one" of the project: Kankakee, Livingston, McLean,

Ford, Iroquois, Putnam, Marshall, Woodford, Tazewell, Stark, Peoria, and Fulton. Assisting in "phase two" were: Monroe, St. Clair, Clinton, Bond, Montgomery, La Salle, Grundy, Kendall, and Will counties, and assisting in "phase three" are: Cook, Randolph, Washington, Jefferson, Perry, Jackson, and Franklin counties.

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Lucius C. Hollister, Jr.
Peter Vanikiotis
Lawrence J. Lawson, Jr.
George P. Guibor

COMMITTEE ON TUBERCULOSIS

With tuberculosis the number one public health contagious disease problem in Illinois, the committee has devoted it's efforts to methods of locating and treating this disease.

The committee submits the following:

Recommendation 1: That TB testing be conducted on a larger scale than in the past; that all children under school age get a TB test annually and that this be repeated every four years with the required school physical exams; and that the tests be continued as a routine procedure in all adult groups as a part of their general physical exams.

Recommendation 2: That TB testing be done with the Mantoux test using 5 international units (5 TU) of PPD (protein purified derivative), or the Heef method, and that local tuberculosis authority provide the tuberculin.

Recommendation 3: That every positive reactor have a chest film which should be read by a radiologist or a chest physician and the results reported to the proper authorities. Such results should also be reported to the family physician, and the family of all positive cases should be tested by a tuberculin test and an x-ray if one is indicated.

Recommendation 4: That the importance of a TB test in pre-employment and industrial physical exams be stressed in an educational program. In these examinations, the skin test is recommended for all persons up to thirty years of age, and an x-ray for those past thirty.

Recommendation 5: That recent converters to tuberculin among children and young adults be treated prophylactically by using INH in dosage up to 10 mg./Kg. for at least one year; and that shorter or interrupted periods of this therapy are to be condemned. That the appropriate drug therapy products be provided by the local tuberculosis authority.

Recommendation 6: That active therapy be based on the three principles outlined by the American Thoracic Society as follows:

1. Combined chemotherapy—the concomitant use of two or more drugs to delay, or to prevent entirely, the emergence of bacterial resistance to any of the drugs used.
2. Continuous administration—administration of the drugs without a break of more than one or two weeks. This is both a safeguard against relapse and an aid in preventing bacterial resistance.
3. Prolonged administration—administration for at least a year, usually longer, to prevent relapse.

Recommendation 7: That all county medical societies be asked to approve the principles inherent in the above recommendations and that they assume leadership in implementing them.

The committee hopes the adoption and implementation of these measures will contribute to the early detection, improved treatment, and ultimate eradication of tuberculosis.

William E. Adams
Chairman
William J. Bryan
Frank H. Fowler
Clifton F. Hall
James H. Hutton
Charles A. Lang
Charles K. Petter
Darrell H. Trumpe
George C. Turner

Resolutions

RESOLUTION NO. 1961-1

INTRODUCED BY: Madison County Medical Society

SUBJECT: Joint Commission on Accreditation of Hospitals

REFERRED TO: Reference Committee on Constitutional Committees

WHEREAS, the Joint Commission on Accreditation of Hospitals is not controlled by the House of Delegates of the AMA, and

WHEREAS, the Joint Commission on Accreditation is a policy making body whose decisions vitally affect the medical care of patients by the medical staff of hospitals,

NOW THEREFORE BE IT RESOLVED that the House of Delegates of the AMA hereby terminate its association with the Joint Commission on Accreditation and hopes that the American College of Physicians and the American College of Surgeons will terminate their association also; and

BE IT FURTHER RESOLVED that the Council on Medical Education and Hospitals is directed to organize and direct the activities of a committee whose sole purpose shall be to inspect and advise the medical staff of any interested hospital as to its relations with the public and lay hospital boards.

RESOLUTION NO. 1961-2

INTRODUCED BY: Saline County Medical Society

SUBJECT: Physicians' retirement program

REFERRED TO: Reference Committee on Council Committees No. 3

WHEREAS, other state medical societies throughout the country have considered, and in some cases have developed, retirement programs for physician participation on a voluntary basis:

NOW, THEREFORE BE IT RESOLVED that the House of Delegates authorize the Council to appoint a committee to conduct such a study and to report back at the next meeting of the House of Delegates.

RESOLUTION NO. 1961-3

INTRODUCED BY: Chicago Medical Society

SUBJECT: ISMS a nonpartisan association

REFERRED TO: Reference Committee on Constitutional Committees

WHEREAS, the action by representatives of the Illinois State Medical Society should always be nonpartisan, including statements or representations made in all its publications;

THEREFORE BE IT RESOLVED that the Illinois State Medical Society go on record as being strictly nonpartisan except in those specific instances approved by the Council of the Illinois State Medical Society or its chairman, or by action of the House of Delegates of the Illinois State Medical Society; and

BE IT FURTHER RESOLVED that it is the responsibility of the executive administrator of the Illinois State Medical Society to determine that the publications and public statements by his staff be strictly nonpartisan unless specifically authorized as aforementioned; and

BE IT FURTHER RESOLVED that this resolution be called to the attention of the House of Delegates of the Illinois State Medical Society.

RESOLUTION NO. 1961-4

INTRODUCED BY: Stephenson County Medical Society

SUBJECT: Social Security for physicians

REFERRED TO: Reference Committee on Officers and Councilors Reports

WHEREAS, a vote of the membership of the Stephenson County Medical Society, taken at the annual meeting in January, 1961, revealed that the majority of the society was in favor of social security for self-employed physicians and surgeons,

NOW THEREFORE BE IT RESOLVED that this be brought to the attention of the Illinois State Medical Society and a request be made that the Society again poll the delegates in 1961 in order to determine the wishes of the Illinois

State Medical Society in regard to social security for self-employed physicians.

RESOLUTION NO. 1961-5

INTRODUCED BY: Winnebago County Medical Society

SUBJECT: Medical Laboratories

REFERRED TO: Reference Committee on Constitutional Committees

WHEREAS the practice of pathology, both clinical and anatomic, has been declared repeatedly to be the practice of medicine by the American Medical Association, by the Illinois State Medical Society, by other state and county medical societies, by the College of American Pathologists, and other special professional societies, by courts of record having certain legal jurisdictions, and by opinions of record of attorneys-general of certain states; and

WHEREAS, there are medical laboratory technicians and other nonprofessional persons operating independent medical laboratories on a commercial basis without medical licensure, without adequate education or training, and without proper professional supervision; and

WHEREAS, persons operating such commercial laboratories are not constrained by law or by their education and training to adhere to professional ethical principles guarding the public interest; and

WHEREAS, such commercial laboratories frequently charge fees to physicians under conditions fostering the division of fees between the laboratory and the referring physician; and

WHEREAS, it is desirable to encourage scientists of professional status, such as chemists and bacteriologists with doctoral degrees, to work cooperatively with physicians for the welfare of patients and in the interests of public health; and

WHEREAS, the independent practice of laboratory medicine, generally known as pathology, by persons without medical licensure degrades the practice of medicine and of pathology in particular, is against the public interest, and seriously lowers the medical and scientific standards of medical practice; and

WHEREAS, the continued operation of commercial medical laboratories operated by unqualified persons is not possible without the patronage of the medical profession; and

WHEREAS, the medical profession generally has always placed the common good above self-interest and has adhered to ethical and moral principles;

THEREFORE BE IT RESOLVED that the Winnebago County Medical Society hereby declares that the proper conduct of laboratory analyses is a medical, professional responsibility, and all specimens for such analyses should be referred to laboratories supervised by fully qualified and licensed physicians; and

BE IT FURTHER RESOLVED that copies of this resolution shall be distributed to the membership of the Winnebago County Medical Society and to the secretaries of other county societies of the Illinois State Medical Society; and

BE IT FURTHER RESOLVED that this resolution be presented to the Resolutions Committee of the Illinois State Medical Society by the delegates from the Winnebago County Medical Society for action by the House of Delegates of the Illinois State Medical Society and that further this resolution be presented to the Resolutions Committee of the American Medical Association by delegates from the Illinois State Medical Society for action by the House of Delegates of the American Medical Association at their respective next meetings.

RESOLUTION NO. 1961-6

INTRODUCED BY: Sangamon County Medical Society

SUBJECT: "Third parties" and fees for services

REFERRED TO: Committee on Constitutional Committees

WHEREAS, the current practice of medicine involves itself into many groups and specialties, each with its own specific problems of practice, and

WHEREAS, each group or specialty is individually cognizant of its problems and the value of its services, and

WHEREAS, third party groups are entering into the monetary relationship between physicians and patients in an ever increasing degree, and

WHEREAS, the Council of the Illinois State Medical Society will in the future have to contract with third party groups,

NOW THEREFORE BE IT RESOLVED that in the future, the Council of the Illinois State Medical Society consult with a committee composed of representatives of each group or specialty, such as the American Academy of Gen-

eral Practice, American Society of Internal Medicine, American College of Surgeons, American College of Radiology, etc., before making any final contract with any third party organization involving fees.

RESOLUTION NO. 1961-7

INTRODUCED BY: Jackson County Medical Society
SUBJECT: Annual dues to Illinois State Medical Society
REFERRED TO: Reference Committee on Officers and Councilors Reports

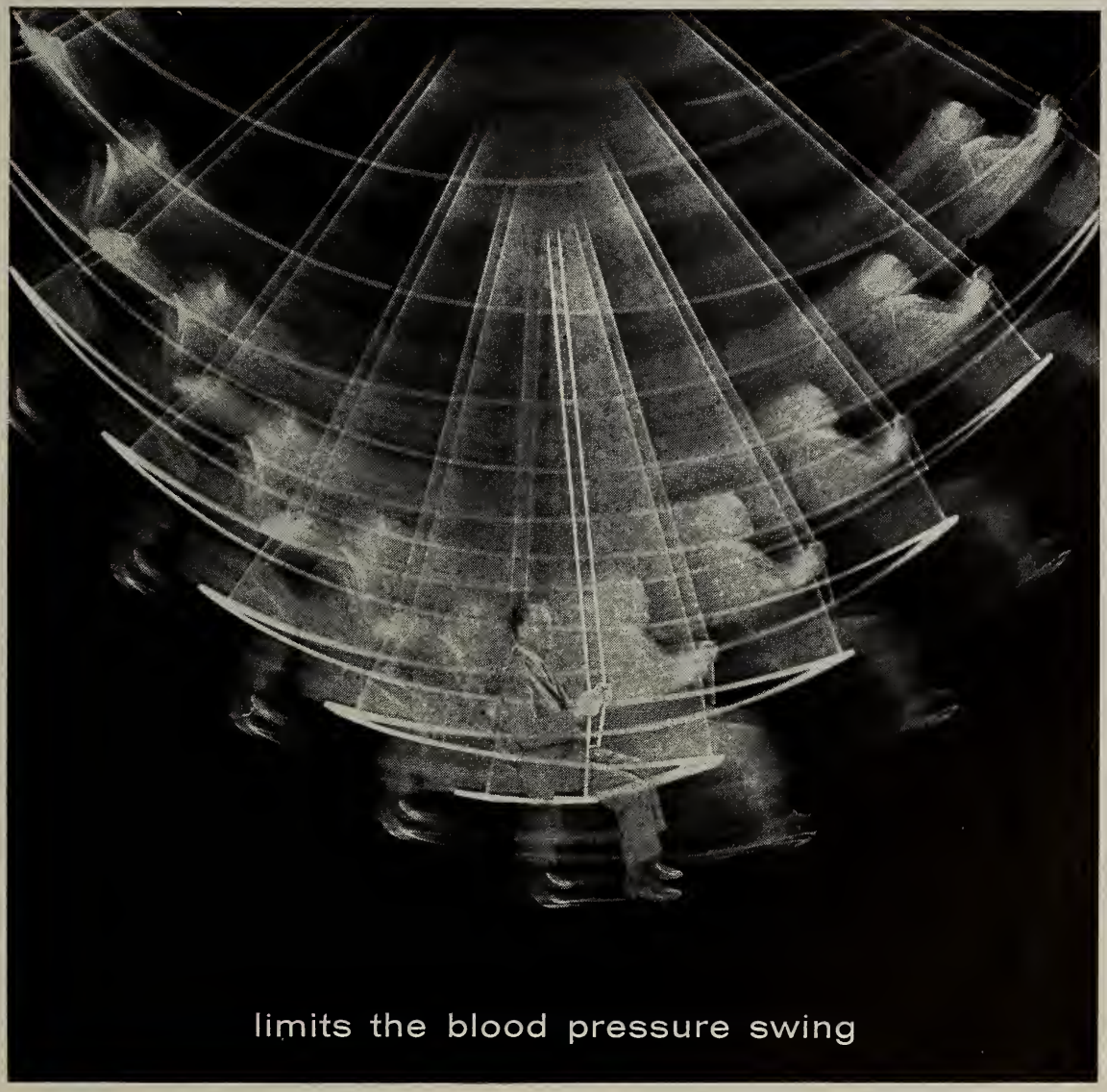
WHEREAS, the Council and/or House of Delegates of the Illinois State Medical Society has caused the annual dues to be raised, and

WHEREAS, the House of Delegates of the American Medical Association has caused the annual dues to be raised, and

WHEREAS, the increased benefits received, or expected to be received, are not apparent or have not been pointed out to the membership,

NOW THEREFORE BE IT RESOLVED that the Jackson County Medical Society accepts the present raise with great reluctance, and hereby instructs its delegates to resist any further raise in dues, and

BE IT FURTHER RESOLVED that the secretary of the Jackson County Medical Society request a statement of the financial condition of the Illinois State Medical Society and the American Medical Association.



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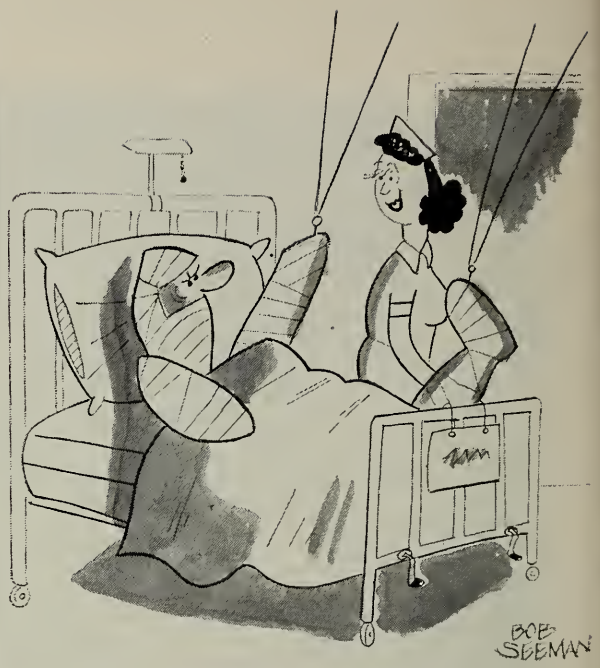
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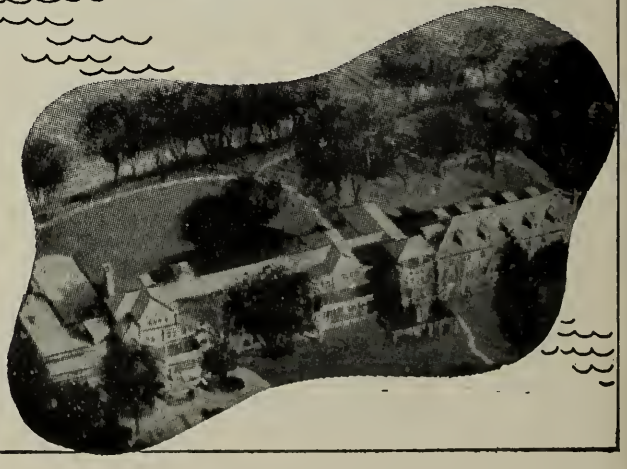
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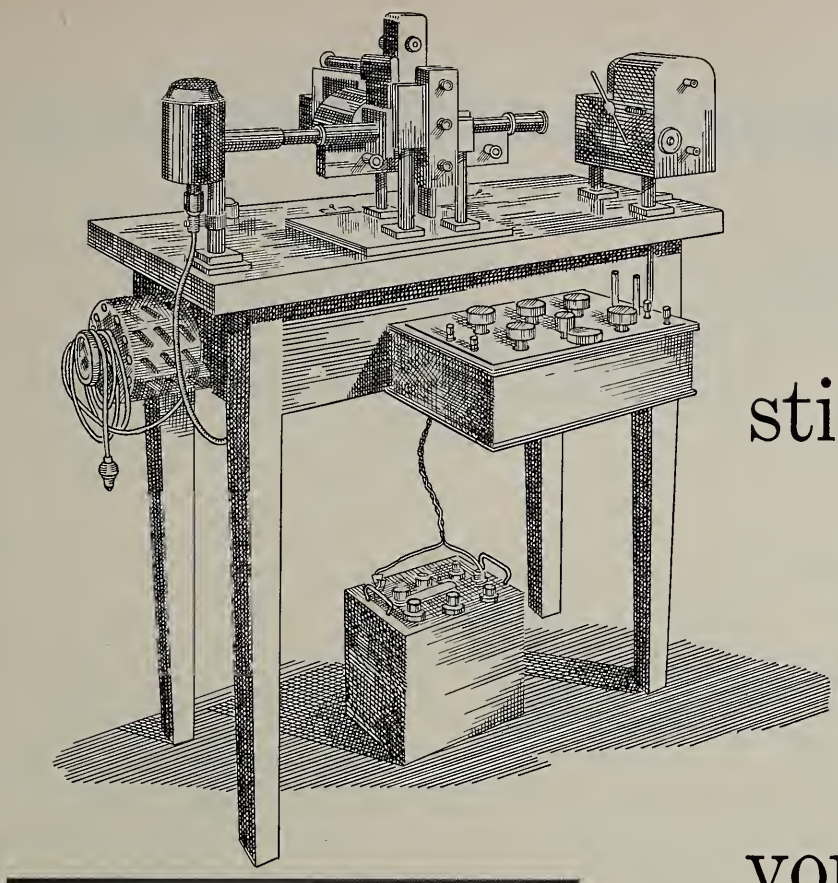
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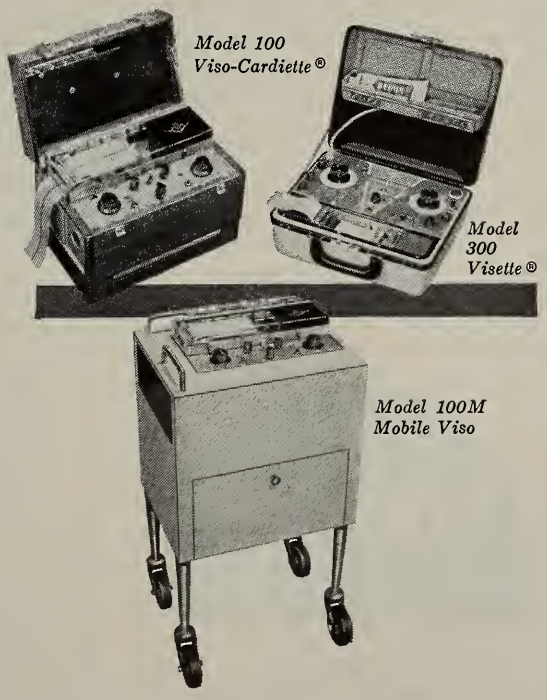




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and how they can be prevented. We must find out how aging can most effectively be managed in order to give our fellow citizens the best possible opportunity for a decent and worthwhile old age, so that as they approach their terminal years, they may best contribute to their own happiness, to their families, and to society at large. This is not a new idea, but it may be that we are finally approaching the time when we can better fulfill the concept expressed by the ancient Greeks, that the art of living consists in dying young—but as late as possible. *G. Halsey Hunt, M.D. Recent Advances in Geriatrics. Pub. Health Rep. December 1960.*



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Vol. 119, No. 5 **May, 1961**

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Published monthly by the Illinois State Medical Society, 360 N. Michigan Avenue, Chicago 1, Ill. Subscription $4.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, Hawaiian Islands, and Mexico. $6.00 per year for all foreign countries included in the postal union. Canada, $4.50. Single current copies 50 cents. By mail, 60 cents.

Second class postage paid at Mendota, Illinois. POSTMASTER: Send notices on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago 1, Ill.

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The Month in Washington



The seriousness of the national problem of mental illness was emphasized on three fronts recently in the nation's capital.

First, the Joint Commission on Mental Illness and Health reported on a comprehensive five-year study of the over-all problem. Second, another special government advisory committee recommended smaller community-sized mental institutions after a two-year study of facilities for care of the mentally ill. Third, a Senate subcommittee held hearings on the constitutional rights of mental patients.

The Joint Commission recommended sweeping reforms in the treatment of mental illness as well as expanded and improved facilities. It said some gains had been made in the past 10 years but that the need for adequate facilities for humane, healing treatment of the mentally ill is still largely unmet. More than half of the patients in state mental hospitals do not receive any treatment, largely because of inadequate facilities, the commission said.

The commission recommended that government spending at all levels—federal, state and local—for public mental patient services be stepped-up in the next decade from the present $1 billion a year to $3 billion a year.

Another recommendation was that there be a fully-staffed, full-time mental health clinic for each 50,000 of population.

The commission, which was created in 1955 by a special act of Congress, had 45 members representing every national association and non-government agency concerned with mental health. The American Psychiatric Association and the American Medical Association had the leadership in setting up the commission.

The government advisory committee, composed of 12 state Hill-Burton and mental health authorities, recommended that states concentrate on smaller community or regional facilities "offering a wide spectrum of services." Dr. Luther L. Terry, Surgeon General of the Public Health Service, urged state governors to use the advisory committee's recommendations as guidelines for improving mental health facilities.

The Senate Constitutional Rights Subcommittee heard from Dr. Winfred Overholser that there is no foundation to charges that many Americans are "railroaded" into mental hospitals. Dr. Overholser is superintendent of St. Elizabeths Hospital, large federal mental institution in Washington, D.C.

Dr. Lauren H. Smith, vice chairman of the A.M.A.'s Council on Mental Health, told the subcommittee that the A.M.A.'s future program in the field will include emphasis on more use of psychiatry in geriatrics, pediatrics, and medical education, both at student and postgraduate levels.

Other activities planned for the A.M.A. program include closer coordination of activities of the A.M.A. council and corresponding committees of state medical societies.

(*Continued on page 23*)

The Food and Drug Administration after the government filed suit against two drug firms for counterfeiting, reported that an extensive investigation showed that there is still relatively little counterfeiting of drugs. Of 2,700 samples of drugs collected from 900 drugstores in the first three months of this year, only nine were found to be counterfeit.

FDA Commissioner George P. Larrick said he expected the problem of counterfeit drugs to continue because of the lure of easy profits. But he said results of the investigation supported the FDA view that "the facts to date do not warrant disturbing sick people about the quality of medications that they have been taking."

In the counterfeiting suit, General Pharmacal Co., Hoboken, N.J., and Lowell Packing Co., Long Island, N. Y., and eight officials of the two firms were charged with manufacturing counterfeit tranquilizers, diuretics, weight reducers, and other drugs and selling them to drugstores in six states. The Justice Department charged that the companies put markings on pills making them appear like other trademarked brands.

FDA ordered manufacturers, effective May 27, to supply samples of new drugs for testing by the government agency prior to clearance for sale.

In the past the FDA has relied largely on scientific data supplied by the manufacturers themselves in clearing a new drug as being safe for sale. The FDA tested the drugs only on a limited and occasional basis and after they had been put on the market.

The government is spending $4.1 billion a year in the health field, a Senate Government Operations Subcommittee reported. In the most detailed report of its kind ever published by a governmental group, the Subcommittee, headed by Sen. Hubert H. Humphrey (D., Minn.), noted that $1.1 billion of the total cares for sick members of the armed forces and their dependents in hospitals. The tab for Civil Service workers' sick leave totals $315 million a year. About $650 million a year is spent on medical research, with most of this carried out by the National Institutes of Health and the Veterans Administration.

The government ordered 250 physicians drafted this year due to the failure of enough interns to sign up for military service. It is the first physician draft in four years. All of the draftees will be assigned to the Air Force. A department spokesman said the draft call would not prevent individual physicians finishing internship this year from volunteering for Air Force medical duty.

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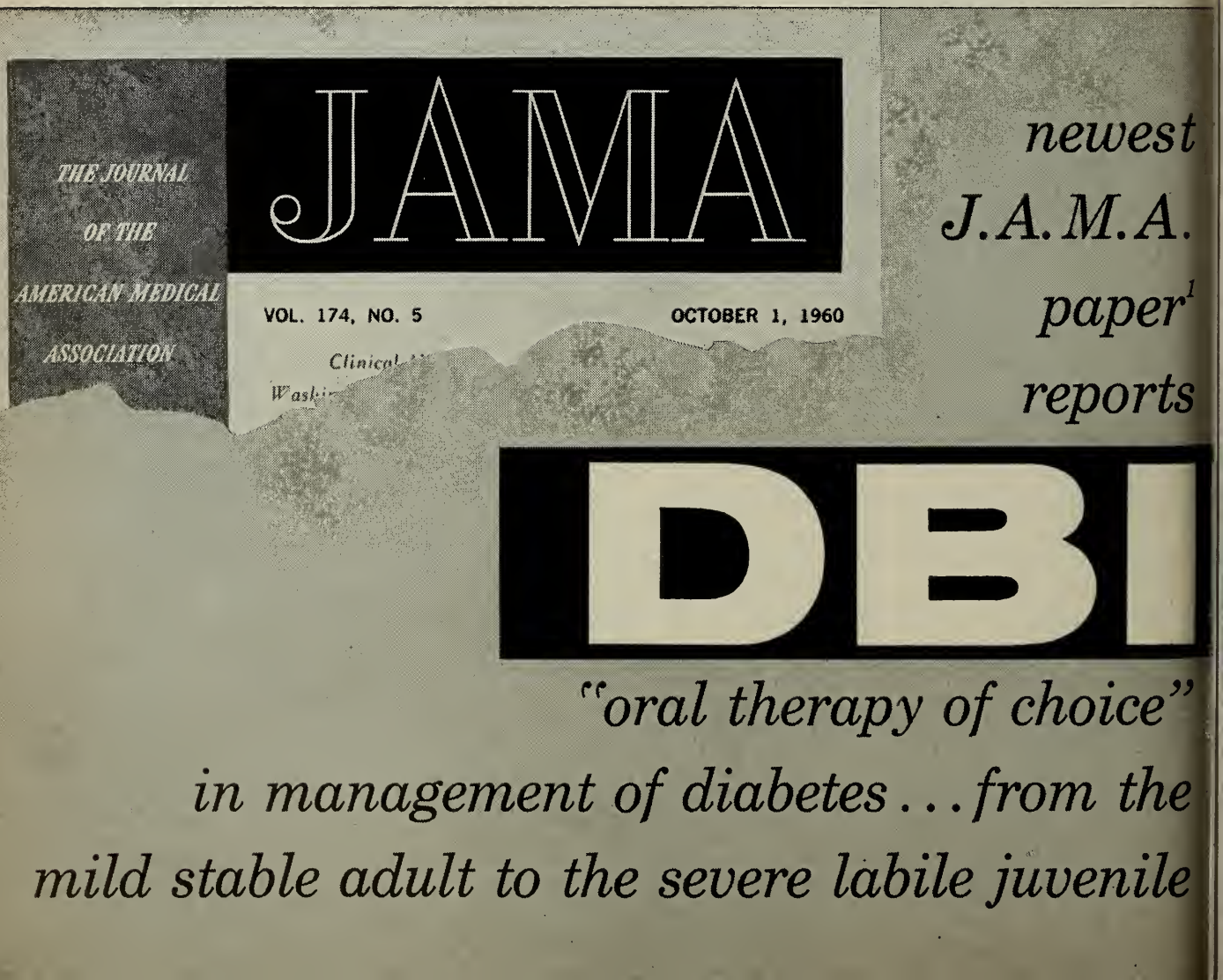
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Whiteside	T. E. Flynn, 101 E. Miller Road, Sterling	Neal Marquis, 101 E. Miller Road, Sterling
Will-Grundy	Leon Gardner, 120 S. Scott St., Joliet	Lawrence Lee, Manhattan
Williamson	F. O. Rupprecht, Johnston City	Martin M. May, Marion
Winnebago	Alfred C. Meyer, 2300 N. Rockton, Rockford	G. T. Burns, 2300 N. Rockton Ave., Rockford Mr. Floyd E. Tarbert, 310 N. Wyman St. Rockford
Woodford	John Sheen, Roanoke	Joseph Phifer, Eureka



The
ILLINOIS
Medical Journal
Official Journal of The Illinois State Medical Society

MAY, 1961
VOL. 119, No. 5

The Delayed Cystogram, An Evaluation

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Persistent or recurrent urinary tract infection in children and infants is not uncommon. Careful diagnostic procedures including excretory urography, retrograde pyelography, and cystoscopy often yield little positive etiological findings. During the past few years, the delayed cystogram has been advocated as a diagnostic procedure of choice in resistant urinary tract infection in infants and children[1,2,5,7,9,11]. In general, we concur with this statement, and it is the purpose of this paper to evaluate this procedure and to present a few representative cases.

The delayed cystogram was first described in 1948 by C. M. Stewart[2] as, "an x-ray of the urinary bladder after instillation and retention of opaque media for a period of one to three hours."

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rarely occurs in the normal person[4,7,9]. It is important to be certain that vesico-ureteral reflux is, in fact, abnormal. A good deal of discussion in the literature concerns this fact. In 1949 Gibson[4] reported in a cystographic study of 330 children under age 14 with no urinary symptoms that seven (2.1%) were found to have reflux. McGavern, Marshall, and Paquin[9] state, "Like fever, regurgitation of reflux may occur on rare occasions for undectectable reasons, usually unilateral and unaccompanied by hydronephrosis. In any progressive spread from normal to ab-

The delayed cystogram appears to be the only method by which vesico-ureteral reflux can be demonstrated. We have, in fact, been surprised by the degree and extent of reflux that can be shown by this method even in the presence of a normal pyelogram.

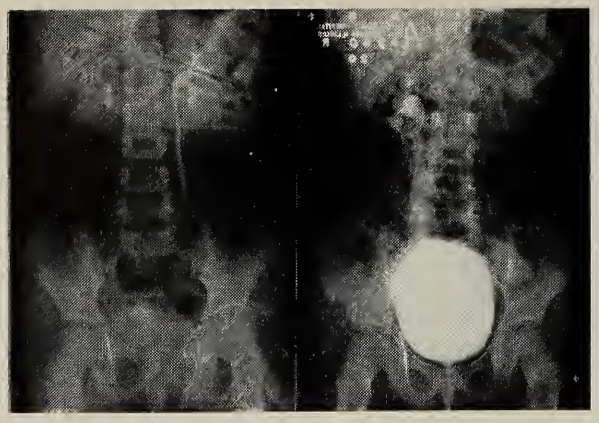


Figure 1. Right: Normal excretory urogram. Left: Delayed cystogram 20 minutes after bladder instillation, with marked right reflux.

It is generally conceded that regurgitation of urine from the urinary bladder into the ureter normal, some borderline of overlapping is expected." These authors conclude that present reliable data do indicate that reflux is extremely rare in normal children. Fulton[3] and many others[11,12] dogmatically state that when reflux does occur, it is a potent factor in upper urinary tract infection especially in infants and children.

Diagnostic techniques and interpretation

To some extent, the reliability of the results of the delayed cystogram depends on the technique used. We have obtained satisfactory results using the method described by Fulton[3]. The examination is best performed without general anesthesia. A preliminary film of the bladder and renal areas is obtained first. A maximum of 150 cc. of five per cent sodium iodide is instilled into the bladder through a Foley catheter which is then clamped off. Serial cystograms are taken at 5, 10, 20, 30, 45 and 60 minutes. After one hour the catheter is withdrawn simulating voiding. An immediate post-voiding film is taken.

We have found that in the young child or infant, 100 cc. of the opaque medium is sufficient. It is not necessary to overdistend the bladder. It is important that a Bardex or Foley type catheter is used and that the small balloon is inflated with air or filled with water. This serves to prevent loss of the medium around the catheter and aids in increasing intravesical pressure necessary to determine the competency of the uretero-vesical orifices. Dean, Lattimer, and McCoy[3] of Columbia University suggest that the Foley catheter be inserted into the bladder while the child is in his bed among familiar surroundings and bladder instillation is begun when patient is moved to the x-ray department. This allays some of the fears and often permits a more cooperative patient. These authors have also instituted a standard technique of instillation into the bladder. The opaque mixture is placed in a sterile flask with sterile plastic tubing and hung from a pole exactly 24 inches (60 cm.) from symphysis of the patient. The solution is allowed to drip into the bladder at 120 drops per minute until fluid stops running. The gravitational method is an excellent one and especially valuable in comparing the progress of the degree of reflux from one time to another. We have found the method described by Fulton very adequate and have not encountered deleterious effects from the procedure. It is important to check films after each exposure since the reflux may be detected on one film and disappear by the next exposure. Frequently, reflux is seen only in the post-voiding film (Fig. 2). Stewart[12] indicated that it may take three hours to demon-

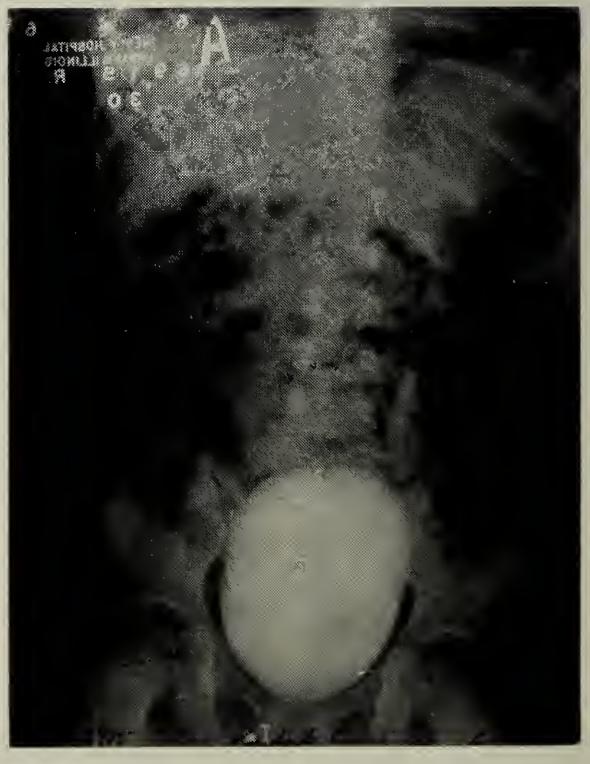


Figure 2. Delayed cystogram showing reflux on left side after partial voiding. Note absence of hydronephrosis; medium showed no sign of ureteral trapping. Patient recovered completely on conservative treatment.

strate reflux into a ureter. It is now generally believed that regurgitation, if present, can be shown in serial cystograms over a period of one hour (Figs. 3, 4).

In neuromuscular uropathy or in chronic bladder neck obstruction, reflux is usually seen immediately. Delayed reflux may be unilateral, bilateral, alternating, sustained, or recurrent. Fulton, corroborated by Iannacone and Panzirone[7], admits that rarely vesico-ureteral reflux may occur in a normal child or infant, but it is distinguishable from the significant varieties in that

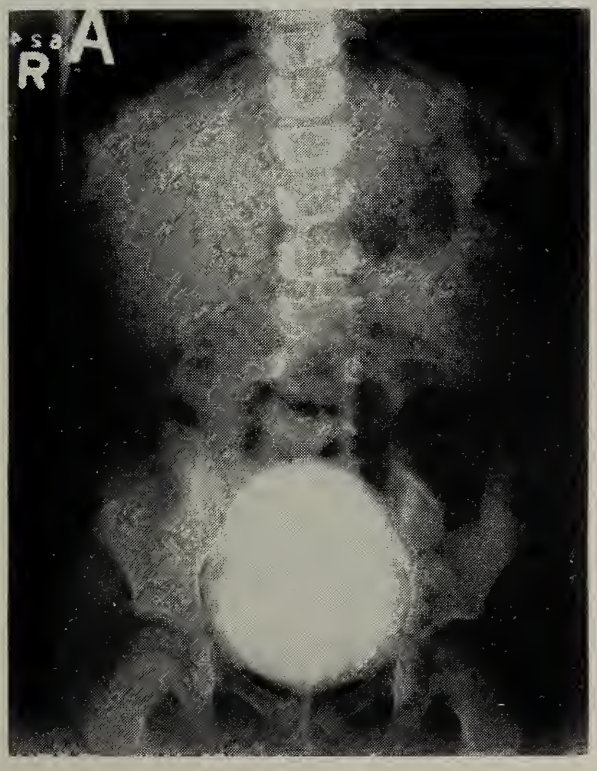


Figure 3. Delayed cystogram: Reflux on left side without hydronephrosis or hydroureter. Patient responded well on conservative management.

it is usually unilateral, transient, nonreproducible and unassociated with dilatation of ureter or pelvis. Iannacone and Panzirone further state that the opaque medium refluxed into ureter or pelvis rapidly disappears and is nonreproducible at the same session or weeks later.

We have found the delayed cystogram a valuable diagnostic procedure, and we advocate its use in all intractable urinary infections in children. Reflux appears to be more prevalent in females. The procedure frequently offers the first clue to the cause of persistent pyuria when the physician is otherwise perplexed by a series of normal findings. It must be stressed that direct visualization of the ureteral orifice as in cystoscopy frequently offers no sign of its incompetency, and therefore a normal cystoscopic examination is of no value in ruling out this condition.

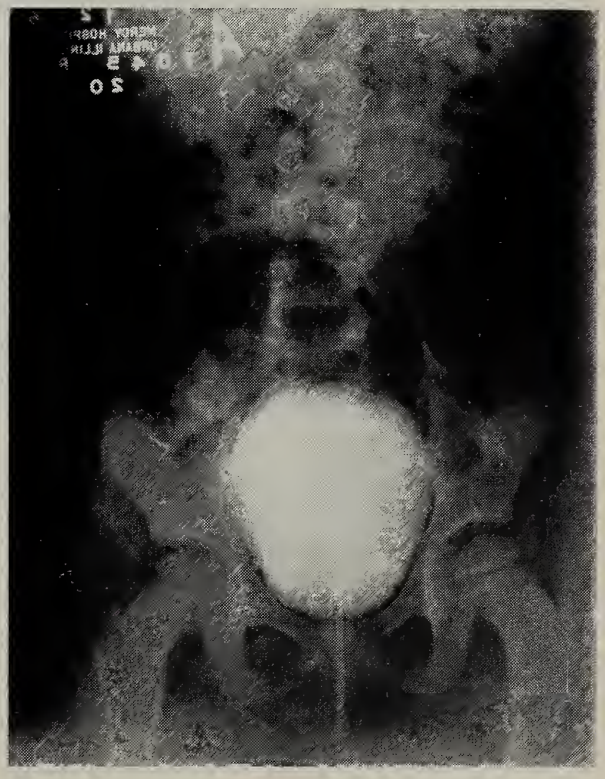


Figure 4. Normal delayed cystogram: No sign of reflux in serial films over period of one hour.

Treatment

We have followed conservative management in all but one of the 15 cases in whom a delayed cystogram was made. We have tried to establish certain criteria as guideposts for more radical procedures in correction of reflux.

These criteria with minor variations are as follows:

(1) Consideration of normal versus abnormal excretory urograms. It is evident that reflux occurring in urinary tracts that also show on excretory urography varying degrees of hydroureter or hydronephrosis are considered a more serious problem than reflux occurring where the excretory urogram is entirely normal (Figs. 1 and 5). [Figure 5 on next page]



A B C

Figure 5. A. Left retrograde cystogram showing dilated left ureter and coiling of the catheter within the ureter. B. Delayed cystogram showing marked degree of left hydronephrosis and hydroureter. C. Postoperative excretory urogram showing marked improvement in the status of left kidney and ureter.

(2) The extent of bladder neck pathology and whether obstruction exists is the second factor to be considered after reflux is demonstrated. Cystoscopy helps, but occasionally it is difficult to evaluate the amount of obstruction at the bladder neck by cystocopy. The degree of trabeculation must be carefully observed. The question of whether the bladder is atonic or contracted is answered by correlating the findings with previous x-rays and the clinical course.

(3) The third factor in the over-all management of these children concerns itself with the clinical course. In only one of the 15 cases reviewed for this study was hydronephrosis or hydrourter demonstrated (Fig. 5). In all of the other children conservative treatment was initiated as soon as reflux was demonstrated.

In general, conservative treatment involved assuring the youngsters of adequate fluid intake. The mothers were carefully instructed with regard to toilet habits; they were encouraged to have these children remain on the toilet a sufficient length of time and in a relaxed mood to encourage complete emptying of the bladder. Several mothers were instructed to insist that their children empty the bladder under the above conditions every two hours. Mothers were instructed to watch the children for evidence of even minor episodes of infection; they were particularly instructed to watch for frequency and evidence of discomfort on voiding. Frequent studies of the urine were made, and thorough treatment was carried out in even the most minor degree of infection.

With one exception, strictures or minor degrees of inflammatory hyperplasia involving the bladder neck were treated conservatively. This consisted of dilatation or light fulguration of inflammatory cysts in the bladder neck and proximal urethra. Repeated excretory urograms were normal. All but one child made such satisfactory clinical progress that it was felt that there was no need for a more radical type of treatment.

This youngster had a hydroureter and hydronephrosis (Fig. 5). Cystoscopy revealed a definite contracture of the bladder neck with evidence of muscle-bundle hypertrophy, and there was cystitis associated with a definite degree of atonicity. The left ureteral orifice was extremely patulous as compared to the right. The contracture was corrected with a modification of the Bardford-Young operation. A segment of the

posterior quadrant of the bladder neck was removed. Exploration during surgery confirmed the associated findings. The ureter was divided and re-implanted in the bladder by a modification of the tunnel and cuff technique.[10]

The postoperative course was without incident, and she continued to be symptom free for five months. A minor episode of pyuria followed a severe upper respiratory infection. After this episode subsided, an excretory urogram (Fig. 5) revealed slightly irregular and larger upper calyces. The other calyces were of normal size, and it was concluded that there was no evidence of hydronephrosis or hydroureter. We did not repeat the delayed cystogram since the youngster was extremely nervous because of the extensive medical observation to which she had been subjected. The clinical course has remained good, and we expect to do this procedure at a future date.

The problem of neurogenic bladder must also be considered. This involves orthopedic and neurosurgical studies. The treatment and clinical course of this disorder is discouraging. Many can be managed only with the idea of controlling the inevitable morbidity as completely as possible.

Summary and Conclusion

We have presented an evaluation of the delayed cystogram including the technique which we have found most satisfactory. It is our impression that all children suffering from minor degrees of urinary tract infections must have complete studies of the urinary tract including the delayed cystogram, urine cultures, excretory urogram, and cystoscopy. Finally, the indications for conservative and radical treatment were discussed.

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Wonders of medicine

During a lengthy operation, one of our chief anesthesiologists was supervising an endotracheal anesthetic. To his horror he noticed that the upper denture was cracked. He immediately envisioned an expensive lawsuit and began to ponder on how best to remedy the situation. Suddenly a brilliant thought occurred to him. He rushed the broken dentures to his cousin Clem, who was a dentist. He, in turn, after some cajolery, entreaties, and a little cash, prevailed upon a dental technician to make an emergency repair of the broken plate. The anesthesiologist then hurried back to the hospital and, to his relief, found the patient still asleep. The following day on his postoperative visit, the patient said to him, "I'll never cease to be amazed at the great strides made in medicine, but I must admit that this time something very extraordinary has happened to me. I could have sworn I entered this hospital with a broken denture and it appears to be good as new now." *Alec Horwitz, M.D. Yesterday's Memories and Tomorrow's Dreams in Medicine. Med. Ann. of the District of Columbia. December 1960.*

Fat Intake and Metabolism:

Their Relation to Blood Coagulation and Atherosclerosis

J. L. Koppel, Ph.D., and John H. Olwin, M.D., *Chicago*

There is increasing evidence to suggest that excessive fat intake combined with abnormal fat metabolism may promote the development of thrombosis and this, in turn, contribute to atherogenesis. Although until recently this thesis has been based entirely on the results of in vitro studies, it has lately received added support by findings obtained in vivo. It is apparent that the type of fat ingested is important and that clot acceleration is promoted particularly by certain types of phospholipids and by long-chain, saturated fatty acids.

In addition to the effects of fat intake on the over-all clotting mechanism, it has been found that there are specific effects on individual plasma clotting factors essential to the formation of intrinsic thromboplastin and thrombin. Furthermore, excessive lipemia has been shown to promote platelet stickiness and agglutination, phenomena which are considered important factors in the initiation of thrombus formation. It is of interest that these effects on individual plasma clotting factors and platelets are not observed in patients receiving adequate prothrombin-depressant therapy. Of additional interest in this connection is the less specific, although perhaps no less important, effect of lipemia on whole blood itself in promoting the so-called "sludging" phenomenon. Although the occurrence of blood sludging does not indicate the existence of thrombosis, there is little doubt that it contributes to an increased thrombotic tendency, particularly if other factors such as platelets and plasma procoagulants are affected in the same direction. It seems unlikely that an increased coagulability of the blood due to lipemia is important in the absence of endothelial abnormalities and an impaired rate of blood flow. Such an increased coagulability may become significant, however, when superimposed on degenerative changes in the vessel wall or when circulation is impaired.

In addition to the clot-promoting ability of fats, their ingestion has also been observed to inhibit plasma fibrinolytic activity, an effect observed originally in in vitro tests but, more recently, also in vivo. The degree of this inhibition varies with the type of fat ingested, and it appears that the actual inhibitory activity is associated with chylomicra and certain high-density lipoproteins (D. 1.006-1.019). Reduced fibrinolytic activity can be restored to normal by treatment of plasma in vitro with fat solvents, the degree of restoration obtained paralleling the ability of each solvent to reduce or modify the beta-lipoprotein fraction of the plasma. It is not known at this time whether or not some of the fats or their products of metabolism which accelerate thrombin formation are identical or related to those concerned with the inhibition of the fibrinolytic system. However, it is of interest that platelets are known not only to promote coagula-

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The investigations in this field carried on in the Coagulation Research Laboratory, Presbyterian-St. Luke's Hospital were supported by the Medical Research and Development Board, Office of the Surgeon General, Department of the Army, under Contract No. DA-49-007-MD-275 and by the National Heart Institute, under Grants Nos. H-3940 and H-5229.

While the Nutrition Committee of the Chicago Heart Association is sponsoring this article, the opinions expressed are those of the authors and do not necessarily represent the official view of that committee.

tion, but also to possess marked antifibrinolytic characteristics.

Knowledge concerning the ability of fats under certain conditions to (1) accelerate coagulation and (2) inhibit fiibrinolysis has resulted in increased speculation about a possible relationship between clot formation and the development of atherosclerosis. Blood coagulation is now being thought of as a continuous, dynamic process, with fibrin being constantly laid down on the walls of blood vessels and, under normal conditions, constantly being removed by the fibrinolytic system. The suggestion that the development of atheroma may be related to the formation of mural thrombi is supported by findings that such material is deposited on the arterial endothelium and subsequently incorporated in the intima where it gives rise to fibrous thickenings. It is now known that many cases of such arterial thickenings previously taken for overgrowths of the intimal connective tissues have actually been products of mural thrombosis.

In vitro studies in patients with clinical evidence of ischemic heart disease have indicated the existence of an apparently hyperactive coagulation mechanism. Furthermore, subjects with atherosclerosis or a positive family history of it exhibit greater in vivo coagulation changes as a result of lipemia than normal subjects and those without a family history of the disease. It appears that these changes resulting in an increased rate of clot formation are associated with a rise in the beta- and a fall in the alpha-lipoprotein fraction of plasma.

It is of interest that these clinical findings are complemented by animal studies indicating that thromboembolic-produced atherosclerosis shows greater severity and frequency when developing in the presence of a high-fat diet than it does in animals maintained on a low-fat diet intake. It has been found that there is a marked affinity between thrombi and lipids, that the latter rapidly enter thrombi and emboli, and remain associated with the clots throughout their progression from original formation to the eventual, completely organized, fibrous intimal lesions characteristic of atherosclerosis.

In recent years many investigators have reported on the existence of an altered lipoprotein pattern in atherosclerosis. It has been shown that under certain conditions heparin administration prevents the development of atheroma in animals and it has been suggested that it corrects the lipoprotein abnormalities associated with atherosclerosis in man. There is good evidence to support the hypothesis that a delay in the normal rate of removal of triglycerides from the circulation, with a consequent rise in plasma triglyceride concentration, is responsible for the accumulation of very low density plasma lipoproteins in certain disease states. Furthermore, it appears that the major pathway for clearance of alimentary neutral fat from the blood stream involves triglyceride lipolysis by the heparin lipoprotein lipase system.

Deficiencies in the activity of the lipoprotein lipase system have been demonstrated in patients with known atherosclerosis, coronary artery disease, and those with a family history of this latter condition. Although the specific cause and nature of these clearing deficiencies still requires clarification, recent studies indicate that the absence of clearing activity in the three groups of patients mentioned may be due to the presence of excessive concentrations of one or more plasma inhibitors rather than to a deficiency of the enzyme as such. The finding of diminished protamine titration values in atherosclerotic patients together with the recent observations that both thrombi and platelets can act as powerful inhibitors of lipoprotein lipase activity, provide additional suggestive links between hypercoagulability, abnormal fat metabolism and atherogenesis.

Footnote: For a detailed background on the various phases of this subject the reader is referred to the following review articles:

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You can't hold a man down without staying down with him. — Booker T. Washington

The Rodent Control Program in Chicago

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Rats are man's worst mammal enemies, constantly menacing the health and welfare of every American community. They are carriers of some of our worst diseases — bubonic plague, rat-bite fever, dysentery, and typhus, to name a few. They eat nearly anything, and they rear their families at the expense of man; they cause a multi-million dollar economic loss, destroying food, buildings, and merchandise in their search for the essentials of life. Rats breed several times a year and produce from 6 to 22 young in a litter. This reproductive potential is staggering since the offspring from one pair of rats could under ideal conditions exceed 350 million within three years.

Rat life persists in American communities because of indifference and tolerance, due largely to lack of knowledge of the dangerous and destructive character of rats. The tireless rodent enemy could be controlled, neutralized, and rendered harmless if every man, woman, and child in a community would recognize the danger and institute proper measures for rodent suppression and eradication. Few rats would be permitted to exist in or near an abode or place of business if their danger was fully appreciated. Pride, as well as common sense, should impress most Americans with the need for unrelenting warfare against them.

The public should have a clear understanding of the habits of rats and of the best methods for their eradication. Rats, for example, are cannibalistic. They will devour young rats found in nests, eat other rats, and will attack one another under stress. They are able to walk along telephone and electric wires with perfect ease and balance. A rat can jump two feet high, dig two feet into the ground, swim half a mile in rough water, and climb smooth, wide pipes. They are active at night, and habitually use narrow, concealed, out-of-the-way routes.

There are nine signs which are helpful in detecting rat infestation: (1) the presence of droppings; (2) well-defined runways or routes customarily used in their travels, which might be stained black by the oil and dirt in their fur; (3) tracks, usually seen in soft, impressionable surfaces; (4) burrows, made primarily to provide nesting and hiding places; (5) gnawings; (6) evidence of live rats, usually seen roaming at night but occasionally during daylight hours; (7) the bodies of dead rats; (8) the presence of nests; and (9) the characteristic, lingering, musty odor of rats.

Rats prefer to live in secluded, dark, well protected places which are close to an easily accessible food supply. This explains their liking for human abodes and buildings, where unprotected kitchen, pantry, and warehouse facilities insure a supply of food and where double walls, spaces between floors and ceilings, furnish ideal nesting places. Their most common source of food is the open garbage can at the rear of stores, residences, and restaurants. Their reproductive capabilities are limited by insufficient food and the opportunity for nesting and harboring. Well-fed rats thrive in comfortable, well protected quarters, breeding frequently and producing large litters.

To assure successful rodent control in a community, it is essential that a program be supervised by a well trained person, as is the case in Chicago. The progress made by a rodent control program is usually simplified by close cooperation with the municipal fire, police, building, and sanitary departments, and other departments or agencies indirectly concerned with the construction, maintenance, and servicing of buildings. Public distribution of information regarding the purpose, value, and methods of rodent control forms an integral part of an effective program of community education. Assistance ob-

Commissioner of Health, City of Chicago

tained from municipal and civic organizations will materially lighten the work-load of a community health department. As in the case of other important health measures, rodent control requires farsighted planning with continuous application of control measures throughout the year rather than a short-lived public relations campaign. Although the elimination of rats is partially an individual problem, best results are accomplished by the organized efforts of all citizens working through interested public and private agencies.

Chicago Rodent Control Program

The Rodent Control Program in Chicago is conducted by the Department of Streets and Sanitation, the Department of Buildings, and the Board of Health. Rodent control activities are under the direct supervision of the Chicago Board of Health, and specifically under a rodent control officer. The Rodent Control Section of the Board of Health functions in cooperation with various city, county, and state agencies. It baits all buildings that are to be demolished in urban removal and highway and slum clearance projects to minimize rat migration to neighboring areas.

Four station wagons and two vanettes are utilized in the program and are assigned daily to inspectors who investigate complaints of rat infestation received the previous day. Weather permitting, all complaints lodged with the Chicago Board of Health are investigated within 24 hours. As soon as a specific site is investigated, the entire city block is concurrently inspected. If rodent infestation is extant, the entire block is gassed and baited customarily within six feet of the alley line, and when permission is obtained from the resident or the property owner, the whole area is gassed or baited. At least one crew and inspector is assigned to this work daily in a particular ward. To reduce and in many instances to eliminate the rodent population, the same areas are repeatedly poisoned or gassed.

Housing inspectors affiliated with the department of buildings are assigned to inspect rodent infestation occurring in the perimeter of buildings, yards, and alleys. When evidence of rodent infestation is discovered, it is promptly reported to the crew that is engaged in gassing and baiting. If an inspected structure fails to have rat-proof features or if it is found to be rat-infested, the crew foreman issues a City of Chicago Warning Notice to the resident or landlord who is violating the Municipal Code of Chicago. If the violation is not corrected within a reasonable period, warning notices are followed by penalty tickets issued by Chicago Board of Health Sanitary Inspectors. Continued disregard results in court action.

Methods

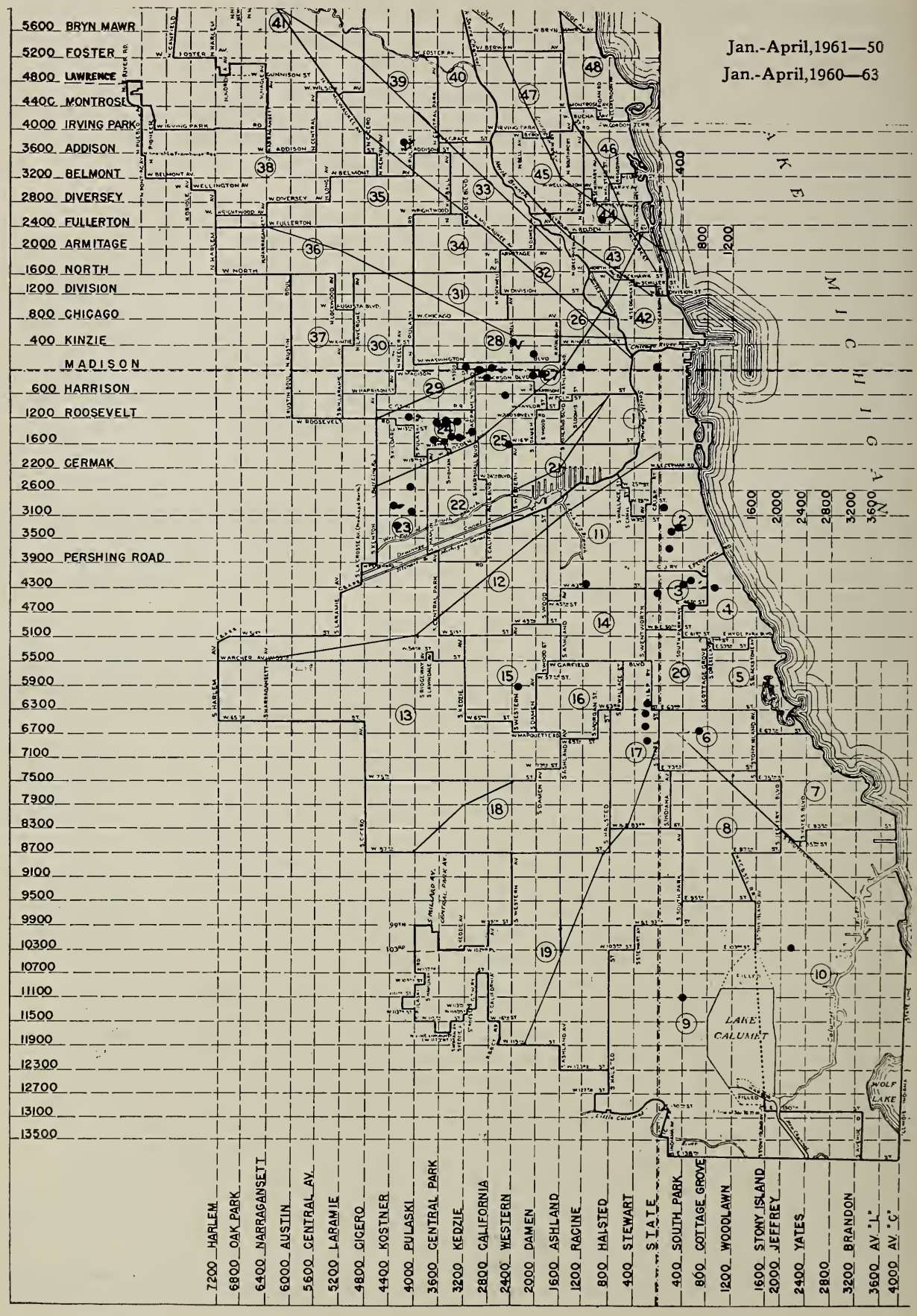
The Board of Health Rodent Control Section uses cyanide gas to eliminate rat burrows not directly connected with inhabited human dwellings. It is pumped into burrows and openings, and an effort is made to seal one end of the burrow. While the use of cyanide gas is most effective for the immediate reduction of a rodent population, the poison produces no lasting response unless warfarin and red squill are employed on a long term basis and citizens in the community comply with the regulations pertaining to proper rat-proofing of structures and garbage disposal. After four or five meals of warfarin, internal hemorrhage hastens death.

TABLE 1.—The Total Amount of Poisons Used During a 4 Year Period by the Chicago Board of Health Insect and Rodent Control Section.

1957		
Units*	12,997	
Red Squill	2,359,739	pieces
Warfarin	179,961	bags
Cyanide Gas	9,064	pounds
1958		
Units*	15,259	
Red Squill	1,529,965	pieces
Warfarin	150,306	bags
Cyanide Gas	3,371	pounds
1959		
Units*	15,938	
Red Squill	1,555,842	pieces
Warfarin	162,972	bags
Cyanide Gas	2,838	pounds
1960 (six months)		
Units*	17,953	
Red Squill	2,076,217	pieces
Warfarin	268,203	bags
Cyanide Gas	3,151	pounds

**Consists of one city block gassed and baited on both sides of the alley and yards, 6 feet of the alley line.*

Location of Rat Bite Cases Reported in Chicago, January to April, 1961.



Warfarin is prepared as a dry grain bait mixture, packed in a wax-lined bag, and carefully placed in out-of-the-way sites, under sheds, sidewalks, and in secluded runways not readily found by children or pets. Red squill is relatively harmless to man and domestic animals, but is lethal to the rat. It is wrapped in red and white wax paper and labeled *Rat Poison*, and is placed in sites out of the reach of children and household pets. Table 1 indicates the amount of poisons used by the Insect and Rodent Control Sections of the Chicago Board of Health during 1957, 1958, 1959, and 1960.

For the years 1958, 1959, and 1960, the Chicago Board of Health has maintained a map showing the geographic distribution of reported rat-bite cases in Chicago (Fig. 1). During 1958 there were 212; in 1959, 212; and in 1960 the total was 219. In general, most cases occur among the lower income groups. The highest incidence centers on the near West Side, the near South Side, and the near North Side — all approximating the center of the city. These areas are characterized by overcrowding, lack of adequate housing, and a low order of personal hygiene and home sanitation. They are populated largely by recent migrants many of whom are unfamiliar with the mores of urban life. White and nonwhite racial groups are equally subject to the restrictions and limitations.

Failure to dispose garbage properly, coupled with the apathy of the residents in a neighborhood or community, predispose to a rodent population explosion. Chicago's vast urban renewal program has helped stimulate the migration of rodents from demolished slum dwelling areas to newer neighborhoods. Hunger and the quest for food often drive rats to bite human beings. Rat-bite cases in Chicago tend to follow definite pathways extending from the center of the city to outlying areas. Many of the pathways for rodent migration follow the course of expressway construction. As a consequence, the Chicago Board of Health, working in close cooperation with the Chicago Land Clearance Commission and the Department of Buildings, has required that whenever a structure is vacated prior to demolition the structure be treated with rat poison or traps to prevent rodent migration.

In Chicago known rat-bite cases are treated either by private physicians or by the resident staff of the Cook County Hospital. For persons unable to afford treatment, the Chicago Board of Health provides free tetanus inoculation. During the past ten years not a single case of rabies attributable to rate bite has occurred in Chicago.

Local medical research

Every town of 25,000 people or more should have a medical research institute so that any physician who has a bright idea, even though in practice, may have a chance to implement it. The possible dividends are staggering—a cure for cancer, a preventive of arteriosclerosis would have immeasurable financial value. It would be perfectly proper for the government to provide matching funds, as is now done in other fields, for the establishment of these small peripheral research institutions. If there is considerable local interest in raising matching money on a philanthropic basis, the government should see to it that matching funds are made available for construction and a certain amount as well for maintenance after the institution has been founded. The encouragement of research in this way is an appropriate function of government and such a plan should be instituted as a supplement to the already well advanced programs of medical research. *Russel V. Lee, M.D. The Role of Government in Medicine. California Med. December 1960.*

Clinical-Surgical Conferences



Cook County Hospital

Acute Appendicitis

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Acute appendicitis, with its complications, is one of the commonest emergencies which the general surgeon encounters. Despite this fact, there is no condition in which diagnosis can be more difficult or obscure, and none in which proper treatment is so necessary to a favorable outcome.

It is extremely important to emphasize, for the benefit of the student and intern group, that yearly 3,000-4,000 patients die in the United States of appendicitis or one of its complications; the feeling that "it was just an acute appendix" is a dangerous one. Appendicitis is a great imitator, and, in turn, is simulated by other lower abdominal disease, the treatment for which is frequently quite different.

Diagnostic considerations aside, many of us have heard a very competent colleague complain bitterly of the "tough appendectomy" he wrestled with at the operating table; most of the time it brings to mind a similar experience of our own and points up the fallacy of considering emergency appendectomy a relatively minor surgical undertaking.

All in all, though operative mortality and morbidity from acute appendicitis have decreased considerably over the last 25 years, most of this improvement has resulted from improved education of the lay public, stressing the significance of lower abdominal pain and the avoidance of enemas and cathartics. We hope, in this conference, to stress some of the less commonly appreciated factors in management of acute appendicitis.

We have called upon two experienced surgeons today to help clear up some of the more difficult problems mentioned. Dr. Chester C. Guy, clinical associate professor of surgery of the University of Illinois College of Medicine and chief of surgery at the Illinois Central Hospital, has been associated with this hospital in the past and is always welcome at these conferences. This particular problem requires considerable clinical acumen; so we feel that he is particularly suited to the discussion. Dr. Donald Kozoll, our second speaker, is an associate in surgery at Northwestern University Medical School and attending surgeon at Cook County Hospital; Dr. Kozoll has written on and been interested in the subject of acute appendicitis for many years.

Case summary:

Dr. R. Ott, surgical resident: This 39 year old Puerto Rican male was admitted to the

surgical service of the Cook County Hospital with a 4-day history of "griping" abdominal pain, anorexia, and a feeling of fullness on eating or drinking small quantities. He stated that the episode was ushered in by a 4-day bout of diarrhea of greenish, watery fluid, unaccompanied by pain but with fever and malaise. He thought he had "the flu," but the abdominal pain had persisted to the time of admission.

Physical examination revealed an acutely ill adult male. His temperature was 101.8F. rectally, pulse 116 per minute, and respirations 24 per minute and regular. He appeared robust. His chest was clear. The abdomen was soft, round, with hypoactive bowel sounds. There was tenderness throughout, most marked in both lower quadrants. No rebound tenderness was present. Rovsing and obturator signs were negative, and Murphy punch was 1+ bilaterally. On rectal examination there was moderate tenderness in all quadrants, and a questionable mass in the cul-de-sac.

The urine showed 2+ albumin, a few white blood cells, no casts. The white blood cell count was 13,700 with a differential count of 68 per cent neutrophils, 22 per cent lymphocytes, 10 per cent eosinophils.

Levine suction and intravenous fluids were started, and the patient was taken to the x-ray department for four views of the abdomen.

DR. BAKER: Dr. Guy, as is our custom, we will call on you first to ask your opinion of this clinical situation, which was a little unique from the standpoint of diagnosis, although I should state that two examiners leaned toward appendicitis. The episode of diarrhea was historical only, but it was certainly impressive; and the fact that the patient had malaise and fever went along with it. He was tender throughout the abdomen and there was no rebound, but there was no question in the minds of the two examiners that he was most tender in the right lower quadrant.

DR. CHESTER C. GUY: This is a very atypical story for acute appendicitis, if this is what the patient had, although such an atypical history is so common an occurrence in acute appendicitis that with any obscure abdominal illness it comes high on the list of diseases to be considered. Perhaps two things impressed me most with this protocol. First, I believe that rather than take the patient to x-ray first, I would perhaps want to see a stool examination or even a proctoscopic examination because of three things: (1) He is from Puerto Rico; (2) his illness included 4 days of diarrhea: (3) the blood count showed 10 per cent eosinophils. Those things suggest the possibility that he has amebic dysentery or other parasitic infestation. We do not see much of that any more, although two weeks ago I operated upon a man with perforation of the large bowel who had acute fulminating amebic dysentery. Therefore, that would be one of the first things I would want to know about.

Secondly, another possibility here, with the diarrhea, is that he may have acute diverticulitis. This is most common in the sigmoid area, although it can occur in the cecum and is often ushered in with diarrhea. Diarrhea is not uncommon in acute appendicitis; about 15 per cent of patients have a bout of diarrhea near the start of their illness. It usually does not last four days, however.

X-ray is perfectly proper, of course. If he has acute diverticulitis, some air may have leaked out and there may be a gas bubble under the diaphragm; but some patients with acute appendicitis have visible intraabdominal air after early rupture.

I would say, in summary, that this patient was suffering from diffuse peritonitis, even though his abdomen is soft. He had been ill for eight days since the diarrhea first started, and he is still quite sick. He has diffuse abdominal tenderness which now we learn is most marked in the right lower quadrant. X-ray is in order, and it might help you, particularly if the bowel pattern is one of ileus. It would then support the diagnosis of peritonitis, and especially if free air is seen in the abdomen. I would think this man should be operated upon, if for no other reason than when a patient has been sick for two days and you cannot rule out acute appendicitis, he must be considered for exploration.

DR. BAKER: This patient with an atypical history was admitted at 9 p.m., and the laboratory technicians left at 4 p.m. Would you feel that stool examination is mandatory? If you proctoscoped the patient and saw nothing, would you go ahead and operate upon him without a stool examination?

Dr. Guy: This man has been sick for eight days. Did he get very markedly worse in the last day or so?

Dr. Baker: Yes.

Dr. Guy: Then perhaps I would go ahead at 9 p.m. with surgery. I think if it were 2 or 3 a.m. I would wait for four or five hours for the stool.

Dr. Baker: Do you feel that x-rays have any place in the diagnosis of acute appendicitis?

Dr. Guy: Yes, but a very minor place. It may help to tell you the degree of ileus present, but you could tell that as well in other ways. If you are satisfied that the diagnosis is acute appendicitis, I would not bother with the x-rays, but it may help if you are not satisfied, which is the case here.

Dr. Baker: If you saw a patient in the home who had appendicitis, would you order x-rays on admission to the hospital?

Dr. Guy: The only time we order x-rays is when there is a suspicion of cardiopulmonary pathology. Then we x-ray the chest.

Dr. Baker: The x-rays did not help at all in this case. The patient was operated upon, and an acute appendicitis was found and the appendix removed. Subsequent stool examination was done and revealed *Endamoeba histolytica* cysts, but no trophozoites, and we postulated that he had had an episode of amebic dysentery. He was treated with chloroquine and diodoquine and had no more diarrhea.

Since Dr. Love of the radiology department is here, we will ask him to show films in which the diagnosis can be substantiated on x-ray. I should like to go on record as saying that I think if you have to rely on x-ray to arrive at a diagnosis of acute appendicitis, you are in serious difficulty. This is *not* an x-ray diagnosis, and we show the films only to confirm the fact that sometimes there are x-ray findings that are suggestive.

Dr. Leon Love: I became interested in the problem of acute appendicitis a few years ago and have been able to make the diagnosis in some cases which were unusual; appendicitis was not definitely diagnosed and the patient was sent down for routine views of the abdomen. Some of the findings are very interesting. There may be, for instance, some localized ileus and dilated loops of small bowel in the region of the right

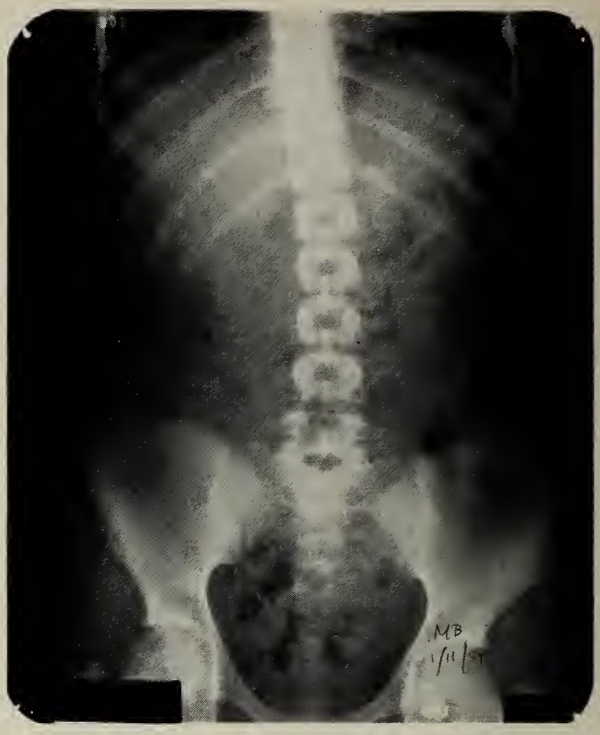


Figure 1. The right psoas shadow is absent, the concavity of the spine is to the right, and there is a fecalith in the right lower quadrant (arrow).

lower quadrant (Fig. 1); so we have an abdominal condition which is acute, and we look for more involvement. You may see the left psoas shadow well outlined, and the right, obscure. Therefore, we have a finding which suggests pathology in the right lower quadrant, and that is localized ileus with loss of the definite markings of the right psoas shadow. On the left side we see that the properitoneal fat stripe is well outlined, but on the right it is hazy and the markings are somewhat poorly identified. Therefore, we have another sign which leads to the diagnosis of appendicitis. We look at the lumbar spine and see that it is flexed, away from the right side. The concavity of the spine is on the right, which suggests that the patient is splinting and pulling away from the side with the pathology. Thus far, there are four signs, and if you look for one more to clinch it, we note calcific densities above the iliac crest at this level, calcified fecaliths in the appendix. So we have all the signs to diagnose an acute gangrenous appendicitis. This particular individual had an acute gangrenous appendicitis with phlegmon.

This is another case (Fig. 2) of localized ileus of the small bowel on both sides and the psoas



Figure 2. Flat film of abdomen showing small bowel ileus and large radiodensity in the right lower quadrant, indicating an appendiceal abscess.

shadow is sharp on the left, but we make out densities in the right lower quadrant. On the original film there is an appendiceal calculus visualized.

Here on a decubitus film (Fig. 3) is an air-fluid level in the cecum, and it is felt that in cases of acute appendicitis, when the patient has not had an enema, 85 per cent will show short air-fluid levels in the cecum, which we see here. We cannot see a calculus, but we see the distention of small bowel; so we have enough evidence for a diagnosis of acute gangrenous appendicitis, and that was correct.

Most cases of acute appendicitis are not x-rayed because they are diagnosed correctly by the clinician and are operated upon, but these films represent the problems that have the clinician baffled, and these are the cases that are sent to us for further information. We have picked up a number of such cases.

DR. BAKER: Does the patient with simple acute appendicitis without perforation get an air-fluid level in the cecum?

DR. LOVE: Yes.

DR. BAKER: How useful a sign is this?

DR. LOVE: We see many air-fluid levels in the cecum from other reasons, but if every patient with acute appendicitis were x-rayed, you would find about 85 per cent of them had air-fluid levels. However, we cannot make a diagnosis on that finding alone.

DR. BAKER: Dr. Kozoll, we would like your comments on this problem.

DR. DONALD KOZOLL: My experience with x-ray has been only that it shows the presence of a calcified fecalith. I wonder if many of these other findings are not related more to appendiceal peritonitis following rupture; that is a stage of appendicitis where we would rather not find ourselves.

DR. LOVE: I think it is frequently inflammation and not peritonitis.

DR. KOZOLL: Some degree of peritonitis is the explanation for many of these findings, and I feel that abscess, perforation, and peritonitis are evidence of neglected cases which must be avoided. The fact is that improvement in the diagnosis of appendicitis has been so remarkable that conferences such as this one are unfashionable. You scarcely hear appendicitis discussed any more, but there was a report from a group in Fort Wayne of 391 cases of perforated appendicitis without a single death, and a report from Boston City Hospital of 1,300 cases of acute appendicitis in children with but one death. The Mayo Clinic reported a large series without a death. Undoubtedly, the fact that there was no death was probably a motivating factor in reporting these experiences, but it has

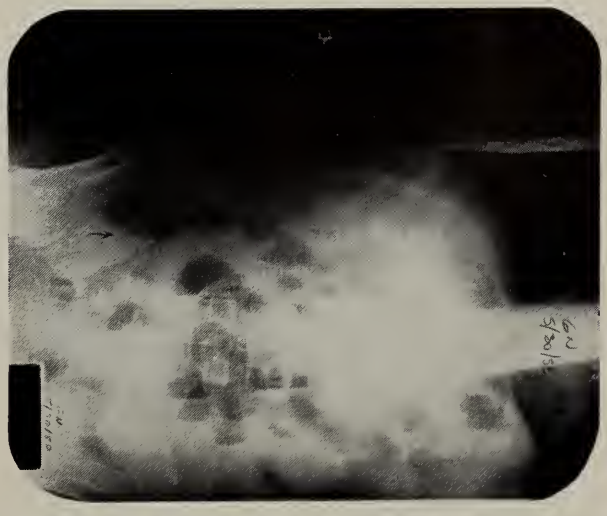


Figure 3. Left lateral decubitus view, with arrow indicating cecal air-fluid level.

given rise to a complacency in the minds of the laity as to the seriousness of appendicitis. The lay press no longer considers appendicitis a significant cause of death, but in 1952 the U. S. Public Health Service figures showed that more than 250 people died in this country every month of acute appendicitis. Undoubtedly deaths from appendicitis are due to complications of peritonitis, perforation, abscess formation, and so on.

I would like to mention the results of our experience at the Cook County Hospital with this condition reported by us in 1947. In that study of over 5,000 cases we compared definite periods to attempt to account for the improvement in the management of acute appendicitis. The mortality rate was not a problem, and antibiotics were not necessary. Only surgery was required to salvage the patients without perforation. I am sure the drop in mortality was actually the result of better anesthesia, and this situation is responsible for our present day complacency. It is important to appreciate that we do see cases of appendicitis with complications, and this is where the difficulty lies. We see decided improvement in the patients with perforation, we believe largely as a result of better treatment of peritonitis rather than the appendicitis itself. The problem of abscess formation is ever present, and some principles of treatment were learned right in this institution, with Dr. Edwin Miller primarily responsible for that. The reason for the improvement in these cases of abscess formation is apparent from an analysis of the patients with appendiceal abscess. In those earlier decades when they were operated upon, the mortality rate was high; but when they were not operated upon, we had a lower mortality rate, and these were patients without benefit of any chemotherapy or antibiotics. From this information was formulated the principle of not operating upon the patient with abscess, and that principle has stood the test of time. In the later decades, even with antibiotics, the nonoperated cases still did better than those who had operation.

The problem in appendicitis centers primarily around preventing perforation, preventing peritonitis, and preventing abscess formation. Inasmuch as patients may procrastinate for three or four days before coming to the hospital, there is not much we can do about that situation because appendicitis is a progressive disease. You rarely see patients with an abscess who have less than a four or five day history, and that is an important detail.

Dr. Baker: We have two of our attending staff here today, Dr. Irving Stein, Jr., and Dr. Roscoe C. Giles. I would like to ask all four men the same questions in regard to surgical management of appendicitis. Dr. Guy, what kind of incision do you use for appendectomy?

Dr. Guy: I must qualify my answer as to the condition and how certain I am of the diagnosis. A year or so ago I had a woman of 35 who had as typical story of acute appendicitis as you can imagine. There was no question in anyone's mind. So, contrary to my usual approach, I made a McBurney incision and later had to enlarge it because she had a twisted cyst of the left ovary. In males, when I am usually more sure of the diagnosis, I do a McBurney muscle-splitting incision. In males when I have some doubt about the diagnosis, I use a right paramedian incision with lateral retraction of the rectus muscles. In females under the age of 14 years when I am satisfied with the diagnosis, I do a McBurney incision; but if they are over the age of 14 years, I use a right paramedian muscle-retracting incision.

Dr. Baker: When you take the appendix out, how do you handle the stump?

Dr. Guy: The management of the stump of the appendix was one of the most hotly debated subjects in surgery 25 to 30 years ago, and there was a great difference of opinion. To answer your question, in recent years, after removal of an appendix with a healthy base, I am content to ligate it with catgut, cut the appendix off 1/8 inch distal to the ligature, touch the stump with phenol and alcohol, and that is all. To the best of my knowledge we have never had a blowout of the stump treated in that fashion. If the gangrene or inflammation extend to the base of the appendix or into the wall of the cecum, then we may ligate it with catgut, but I invert that stump with healthy cecal wall reinforced with additional serosal sutures of black silk. Blowout of the appendiceal stump is much more apt to occur when the stump was diseased in the first place and when the surgeon depended upon a ligature alone without inversion.

Dr. Baker: What about drainage of the area?

Dr. Guy: We use intraperitoneal drains when we are dealing with frank, well walled-off abscess or when we have removed a gangrenous retrocecal appendix and when there is a great deal of active inflammation or purulent material in the retroperitoneal space. In those, I put two Penrose drains into the peritoneal cavity. In other cases we wash the wound very thoroughly, first aspirating the cul-de-sac to get the pus out; then we close the peritoneum tightly with catgut, close the other layers with interrupted sutures, and wash those layers thoroughly. We insert a Penrose drain down below the fascia.

Dr. Baker: Do you use antibiotics in the peritoneal cavity?

Dr. Guy: We have done so in recent years with an exploded appendix, a very acute diffuse peritonitis, or with a patient sick for 48 hours. In such a case we have put in large amounts of antibiotics. We have used as much as 5 million units of penicillin. I have also used solutions of Chloromycetin® up to 3 Gm.

Dr. Baker: Have you regretted the use of these drugs?

Dr. Guy: No, but I don't know whether it did any good. We have not seen any reaction from this.

Dr. Baker: Dr. Stein, what about the incision?

Dr. Irving Stein, Jr., attending surgeon: I agree with Dr. Guy. The McBurney incision is the best incision and is preferable if you are certain of the diagnosis. If you are not certain, do a paramedian or low midline incision.

Dr. Baker: Why is the McBurney best?

Dr. Stein: It heals faster. There will be fewer hernias following it. If it gets infected, it generally does not lead to trouble. There are no eviscerations through a McBurney. The patient will be back to full activity very shortly after operation. We cannot say that after a muscle-retracting incision.

As to treatment of the stump, we invert them all. We do not use phenol and alcohol any more. All we do is ligate the stump and touch the open end with a dry sponge to remove mechanically any fecal material. Then we put a purse string suture in and allow the stump to be inverted. We ligate with plain fine catgut so that it will open up inside the bowel within two days. Phenol was used at one time to coagulate the mucosal lining of the part left behind, but you can still get a mucocele, although I have never seen one. We invert them all, and feel much safer that way.

As for drainage, we drain the peritoneal cavity only when there is abscess formation or a retrocecal appendix, but we do drain the wound if it is a gangrenous appendix or in cases of purulent peritonitis. You sometimes have purulent fluid in the peritoneal cavity which does not have an odor; that kind usually does not cause infection. But if the fluid has an odor, it will cause wound infection. In the muscle-splitting type of incision you may not have infection, but in the fat individual we drain to the peritoneal cavity to allow pus to come out, because half of those patients will have some drainage and if you close them up tight and stop antibiotics, they will have abscess or infection, usually subfascial.

We do not use intraperitoneal antibiotics. If you have removed the appendix, the peritoneum takes care of the situation much faster than if you instill antibiotics. But, if you give systemic antibiotics, within 48 hours the peritonitis has subsided, even in cases of marked contamination of the peritoneal cavity. The peritoneum is the first structure to recover. The combination of streptomycin and penicillin is a good one for appendiceal peritonitis. Chloromycetin is an excellent drug, but more dangerous.

Dr. Baker: Dr. Kozoll published an article in which he stated that the further lateral the incision the better, and we would like to hear his comments.

Dr. Kozoll: About 88 per cent of appendectomies performed here were through a McBurney incision. In the McBurney group in the earlier decade, the mortality rate of all types of cases was 19.2 per cent. This dropped to 3.4 per cent in the subsequent era. About 10 per cent of the incisions were right rectus, and I would concede that the closer to the midline the more the diagnosis was in doubt and the more difficult the case, so there may be some artificial separation of these cases.

I must confess that we have always taught that it was preferable to make a McBurney incision, and if in error, to close that and make a second incision. The advantages lie not only in the mortality rate but in the morbidity rate as well. I don't remember any patients who were unhappy or refused to pay their bills or did not

come back because they had two incisions. You can do a lot through a McBurney incision, as you know, with extensions. One of our residents reviewed all our ventral hernias, and I remember that the right rectus and paramedian postappendectomy incisions accounted for the bulk of the hernias after appendectomy. I can remember when abscesses were more common than they are now, and with a McBurney incision you could put a hard rubber tube down to the abscess, wrap it with iodoform gauze, and use no sutures in closure. I cannot remember an evisceration. I do remember a rare herniation, however. I still am very much in favor of a McBurney incision whenever possible, and I would rather employ a second incision when there is an error in the diagnosis.

On the management of the appendiceal stump with inversion, as Dr. Guy has said, there has been controversy. The big question has been what happens to the ligated base and purse string inversion; it was felt that this created an abscess by closing the serosa of the cecum over the cut tip of the appendix. Everyone is influenced by his personal experience, but I have seen bases blow out in removal of normal appendices, with fatality. I have seen enough of that sort of thing at autopsy that I am careful not to leave the appendiceal stump free, but always close the cecum over it. If I could not invert the stump, I would put a drain down at this point, so that a fistula rather than peritonitis would result in that case. I think the ligature around the base is most important. Patients who bleed postoperatively have not had a ligature placed around the stump. I would like to compare this situation with what we do in gastric resection when we divide and invert the mucosa. When we divide the duodenum, we turn the mucosa in with a series of sutures, and I am unaware of reports of abscesses of the inverted duodenum. Where you use a Billroth II modification and invert two thirds of the lesser curvature of the stomach and oversew it with a series of sutures, I am not aware of abscesses being a problem. This holds similarly throughout the bowel where we invert the muscosa. I think where we have had abscesses has been in inverting gangrenous tissue.

Dr. Roscoe C. Giles, attending surgeon: I would like to bring in the matter of prophylaxis of appendicitis. Many of the complications come from outside forces. For example, Bauer of Philadelphia was able to reduce the mortality in acute appendicitis from 10 to less than 5 per cent by persuading the pharmaceutical association not to sell a cathartic to any patient who came into a drug store complaining of abdominal pain, without advising that patient that the pain might be due to appendicitis. That is how he reduced the mortality in his community.

As to the use of antibiotics in the abdomen, I stopped that after surveying the literature. At one time it looked as though neomycin might be valuable, but now we feel it can cause serious complications, particularly respiratory arrest.

Dr. Baker: What would you do if you operated for appendicitis and found regional ileitis instead?

Dr. Guy: I would leave the appendix in.

Dr. Kozoll: I would leave the appendix in. I think that it is bad judgment to remove it. I cannot remember a patient with regional ileitis treated conservatively who developed appendicitis.

Dr. Baker: If you have made a McBurney incision and found a mesenteric adenitis, would you take the appendix out?

Dr. Guy: Yes, as a rule. If you are in there and you do not believe you will aggravate any other pathology, it only takes a moment or two and you are justified in doing it.

Dr. Kozoll: I think that is generally practiced.

Dr. Baker: If you explored a patient with the diagnosis of appendicitis and found acute cecal diverticulitis, what would you do to the appendix? Would you leave it in?

Dr. Guy: I have met that problem because acute diverticulitis cannot be differentiated from acute appendicitis clinically; this poses a real problem. You have to handle each case on its individual merits. I have seen some diverticula that were perforated, and the perforation was closed and nothing else was done. In general, I would leave the appendix alone because of the emergency situation, and unless the appendix actually interfered with closing the diverticulum, I would leave it in.

Dr. Kozoll: You have to close the perforation, and I would leave the appendix alone.

Dr. Baker: If the appendix were present incidentally in a right sliding hernia, would you take the appendix out when repairing the hernia?

Dr. Guy: Always. I reviewed our material, 145 proven cases in the last 5 years. I had one death in an elderly man whose general condition was not good. He had an incarcerated right inguinal hernia and he had an acute, suppurative, perforated appendix in the sac. I would take the appendix out in these cases.

Dr. Kozoll: If the appendix is not acutely inflamed, I would not take it out because I would be afraid of infection.

Dr. Baker: Suppose you had a patient with a stab wound of the abdomen which you thought had penetrated bowel, and exploration revealed no intraabdominal pathology. Would you remove the appendix?

Dr. Guy: I think you would do him a favor if you took the appendix out.

Dr. Kozoll: I would face the family and tell them we were sincere about what we set out to do and found nothing, and that we were happy to report that. I would not want to cover up one thing with another. If I had removed the appendix in such a situation and the patient developed signs of peritonitis, this would cause considerable concern. I think one problem at a time is enough.

Dr. Guy: If the patient developed peritonitis, I would feel that I had overlooked a stab wound of the bowel.

Dr. Baker: Do you ever diagnose chronic appendicitis or operate for that disease?

Dr. Guy: No. I believe there is a place for the diagnosis of subacute, and I believe there is a place for the diagnosis of recurrent acute, but I think the term "chronic appendicitis" should be discarded.

Dr. Baker: What do you mean by those terms?

Dr. Guy: I mean recurrent acute attacks which may be mild. By "subacute" I mean the low grade infection where there is a phlegmonous sort of inflammation with a large, swollen appendix, and by looking at it you believe it has been smouldering there for several weeks. This is not a common situation.

Dr. Kozoll: A tumor or prolonged inflammatory reaction may produce a mucocele. With a really acute exacerbation there will be a lot of induration.

Dr. Baker: I am asking about the chronic, low grade right lower quadrant pain present for several weeks or months especially in older children.

Dr. Kozoll: There are intervals of quiescence.

Dr. Baker: Could that be a low grade inflammation of the appendix?

Dr. Kozoll: Yes, about 60 per cent of them will be benefited by appendectomy, and in the interval of quiescence I take it for granted that you have ruled out other possibilities for that pain.

Dr. Stein: There are some things that have been discussed that have been generally agreed upon but that I do not agree with, so I would like to stimulate further thought. What you have heard are the generally accepted but not necessarily universally agreed upon opinions. For instance, in appendiceal abscess the treatment of choice has been conservative through the years, but there is a newer school of thought in which there is evidence that whenever you diagnose appendicitis, abscess or phlegmon, early or late, the treatment is operative. There is no conservative therapy for acute appendicitis in any form. There are hospitals in the East treating them all with surgery. The mortality is about the same today as it is with conservative treatment. We have a series of 50 patients with phlegmon and abscess operated upon without any mortality and with less morbidity. We have not treated later cases of appendicitis conservatively. I am not advocating operation for all of them, because you can get into trouble. You may have to back out once you are in, but you go into these with your eyes open. If you operate on the patient and remove the appendix and drain the abscess, the patient will have a fast recovery. These patients are home in a week or 10 days, but otherwise there may be months of trouble and some will die.

As for regional ileitis, many times in exploration you find that the cecum is all right, but if the cecum is bad and you cannot close the stump, you will get a fistula. If the cecum is all right, take out the appendix and leave the rest alone. I have performed surgery myself for acute re-

gional ileitis where the cecum has been all right and have removed the appendix without trouble. The fistula rate is less if you take the appendix out. There is a definite fistula rate if you do a laparotomy and nothing else and leave the appendix in; so one should not generalize and never take the appendix out in regional ileitis.

As for acute diverticulitis of the cecum, I have a small series of five cases. We did diverticulectomy in these and could close the base just as you would the base of the appendix. We took the appendix out in addition, feeling that there was no additional risk and no point in leaving it in. We felt we were doing the patient no additional harm, and we were in this area; so the appendix should come out.

As for the stab wound, in most cases we would take the appendix out if we found nothing else for this reason: We are in the abdomen and whenever I am in an abdomen and there is no contraindication, I will remove the appendix. If there is pelvic inflammatory disease, appendectomy is permissible. If there is extensive or severe peritonitis, don't touch the appendix.

Dr. Baker: I would like to ask one further question of the panel: Suppose you had a 30 year old man in the operating room with the diagnosis of acute appendicitis and after he was anesthetized, you palpated an abscess; would you wake him up or proceed with surgery?

Dr. Kozoll: I would open the peritoneum and drain the abscess. If the appendix lies free and you do not have to mobilize the cecum, I probably would take it out.

Dr. Guy: Yes, I would go ahead and operate. We treat our appendiceal abscesses conservatively until we are convinced that they are getting worse and have to be drained. We have had them rupture and spread on conservative management.

Dr. Baker: We welcome the differences of opinion that have been expressed here, for they serve to point up the fact that we still have a great deal to learn before all the questions can be settled, even in this very common condition. Our thanks to the discussants for their thought-provoking comments.

Summary and conclusions

1. The most frequent cause of acute appendicitis is obstruction of the lumen, which probably occurs in 80-90 per cent of cases. It may be obstructed by a fecalith or, occasionally, by hypertrophy of submucosal lymphoid tissue.
2. The base of the appendix may always be found at surgery by following the anteromedial taenia to its junction with the other two at the inferior portion of the cecum. The appendix may then lie in one of several directions:
   a. In pelvis, medially
   b. Laterally along iliac crest
   c. Lateral to the cecum, in an upward direction.
   d. Behind the cecum (retrocecal)
   e. Medially and upward, behind the ileum
3. The signs and symptoms of early acute appendicitis classically are:
   a. Abdominal pain, commencing in the epigastrium and rapidly localizing in the right lower quadrant.
   b. Anorexia, nausea, and frequently vomiting.
   c. Slight fever (99 to 100 F.)
   d. Tenderness over McBurney's point.

   One important characteristic of appendicitis is its diversity of symptoms; atypicality is the rule, not the exception, and the surgeon must be aware of this fact.
4. Laboratory tests are not of much value in the diagnosis of acute appendicitis, but, in general, usually looked for are:
   a. Elevated WBC with a moderate shift to the left (12,000 to 15,000 count is the rule.)
   b. Increased sedimentation rate (15-25 mm./hr.)
   c. Negative urinalysis (very unreliable, as a retrocecal appendix may yield both RBC's and WBC's in the urine)
   d. Upright x-ray film of the abdomen (may see cecal air-fluid level or fecalith)

   The diagnosis of acute appendicitis is *always* made at the bedside, never is based on laboratory or x-ray examinations.
5. Acute appendicitis is usually thought of as a five day disease:
   Day 1: Stage of inflammation
   Day 2: Stage of exudation
   Day 3: Stage of gangrene
   Day 4: Stage of perforation and peritonitis
   Day 5: Stage of localization and abscess or of spreading peritonitis and *death.*

   This is a most artificial view, however, and all

surgeons have seen patients perforate on the second or third day or present with an abscess on the fourth day, etc.

6. It is axiomatic that each case of appendicitis is different and seldom will a "typical" case be seen. It is further axiomatic that the only treatment for nonperforative appendicitis is appendectomy as soon as the patient's condition warrants it.
7. Appendicitis is uncommon under the age of five and over the age of fifty. When it does occur at the extremes of age, it is doubly treacherous, for it is usually atypical in nature and unsuspected by the physician. The mortality rate of appendicitis at the age extremes is, therefore, much higher.
8. In perforative appendicitis with peritonitis, the Ochsner regime was formerly popular, suction, intravenous fluids, Fowler's position, and opiates, with abscess formation the desired result. At this time, best results in appendicitis with peritonitis are obtained with adequate preoperative preparation and early surgery, rather than expectant treatment.
9. Complications of perforative appendicitis are:
   a. Appendiceal abscess
   b. Pylephlebitis with or without liver abscess
   c. Generalized peritonitis
   d. Subphrenic abscess
   e. Obstruction of ileum (adhesion or abscess)
   f. Septic pulmonary emboli (from iliac thrombophlebitis)

The yields from prostatic massage

Many men who have no obvious neurotic symptoms are insecure about their masculinity. These doubts rarely come to the surface unless forced by circumstances, especially when normal sexual outlets are unavailable, e.g., during isolated military duty, incarceration in penal institutions, etc. Being prohibited from normal heterosexual activity during the course of treatment for "chronic prostatitis" while being manipulated digitally per rectum could be expected to stir up such latent doubts and fears. This has been observed in some cases to lead to increased symptomatology, regression, anxiety, and depression, alluded to previously. For some patients prostatic massage yields certain satisfactions, leading to a virtual addiction in a guilt-ridden male.

It is suggested, therefore, that the diagnosis of "chronic prostatitis" and the institution of prostatic massage be approached cautiously. In history-taking the physician should inquire into the patient's feelings and attitudes about disease in the genital-rectal area, his sexual activities, phantasies about the meanings of his symptoms, and his concern over his manliness. If there seem to be superficial problems in these areas, simple reassurance may relieve a great many symptoms. On the other hand, more complex conflicts might well be evaluated before treatment by a psychiatric consultation. Certainly when a patient shows no progress with prostatic massage or gets worse, a reappraisal of the diagnosis and course of management would be wise before the complications become irreversible. *Karl Kay Lewin, M.D. Psychosomatic Aspects of Chronic Prostatitis. Pennsylvania M. J. December 1960.*

Criminality among Narcotic Addicts in The Illinois State Reformatory for Women

Bernard F. Robinson.* *Dwight*

The incidence of drug addiction among inmates of the Illinois State Reformatory for Women is related directly to their pre-institutional environment—residence in Chicago. Drug addiction seldom is a factor among inmates from other sections of the state.

Scope and purpose of study

The scope of this study is limited to 56 female offenders who have a history of narcotic addiction and who, at the time of this study, were confined in the State Reformatory for Women at Dwight, Illinois. Each offender was serving a sentence of not less than one year for committing either a misdemeanor or a felony.

The history of drug addiction in each of these 56 cases was determined by the reformatory physician at the time of admission. Drug addiction as used throughout this discussion refers to what Vogel, Isbell, and Chapman define as, "a state in which a person has lost the power of self-control with reference to a drug, and abuses the drug to such an extent that the person or society is harmed."[1]

We are concerned primarily with narcotics and narcotic addiction to the extent that they pose penological and criminological problems that are related to the degree to which the inmates accomplish a suitable intramural and extramural adjustment. We are interested also in discovering procedures that will reduce appreciably criminality among adult female offenders who have a history of naroctic addiction. The conducting of such a study by the sociologist of the reformatory is commensurate with the function of the clinical sociologist employed in a correctional setting, whose chief function is the diagnosis of criminality.[2]

Personal and social characteristics

Of the drug users in the inmate population, 52, or 95 per cent, came from the Chicago area.

The large representation of Negroes in the addict population, 89.3 per cent of the total number of 56, is even more disproportionate than is the high frequency of Negroes in evidence in the general inmate population which is 152 of 239, or 63.5 per cent. In reference to this matter Adams points out "estimates of the narcotic Bureau officials at this time are that 45 per cent of the total addicts (not in hospitals) are colored while 75 per cent of the juvenile addicts are colored."[3]

The racial composition of the inmate population is even more significant when it is realized that Negroes compose only 7.4 per cent of the total general population in Illinois.[4] Furthermore, Negro females in Illinois constitute only 6.6 per cent of the total female population of the state.

By far, most Negroes in the state reside in Chicago. Historically, they have resided in a rather narrow strip on the south side which, although it has expanded in recent years, has done so only after great resistance to restricted covenants, gentlemen's agreements, and violence. More recently the near west side has been populated by Negroes, as have some other areas, as a result of deterioration of the section as a desirable residential area coupled with the ever present seeking on the part of the Negro to find a place of shelter. The long history of being manipulated residentially by realtors and property owners outside of their ethnic group has no doubt had deep psychological effects upon the social attitudes of the Chicago Negro. The fact that most Negroes live in areas that have a high

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Presented before the Physicians' Association, State Department of Public Welfare, 119th Annual Meeting of the Illinois State Medical Society, May 20, 1959.

incidence of delinquency and criminality may throw some light upon the reason for such a disproportionate number of Negro women in the population of the reformatory. It may be observed further that the residence of the Negro group in areas of high incidence of delinquency may bring about a predisposition for them to commit social offenses; thus, the high frequency of drug addiction within the group. Junk is pushed where the population is least well protected and where people are most avidly seeking a way out. The place in Illinois that perhaps is most vulnerable to the pursuit of criminal activity of any sort is the Black Belt of Chicago. Many Chicago Negroes may speculate that after living in criminally infested, deteriorated areas under inadequate social control, being sent by a fix isn't so bad even when you have to go to hell sometimes to meet the man.

Although 28, or 50 per cent, of the 56 inmates were born in 18 states other than Illinois, the remaining 28, or 50 per cent, were natives of Illinois. Of that 28, 24 were born in Chicago. The fact that 11 inmates of the 56 were born in southern states is significant because Chicago probably receives a larger number of Negroes of southern origin than does any other city in the United States. Nevertheless, those who were born outside of Chicago or the state of Illinois still had their origin in urban centers, regardless of the region of the country.

The average age of all women in the general population of Illinois was 32.9 years. The average age of the group under scrutiny was 27.5 years, or 5.4 younger than the general population. The average age of the total population of the institution was found to be 30, or three years older than the group under study. Addicts are considerably younger than both the women in the general population of Illinois and the women composing the general population of the institution.

The educational status of the members of the group under study, in terms of academic grades completed, compares very well with the status of similar groups. The median number of academic grades completed by persons, regardless of sex, who resided in Illinois in 1950 was 9.3. The average number of grades completed by white persons was 9.5, while the average academic achievement among Negroes of the state was 8.5. The average number of grades completed by white females residing in urban areas was 10. Nonwhite females residing in the same urban areas completed an average of 8.5, which is 1.5 years lower than the average number of academic years completed by white female residents of urban areas in Illinois. The average academic achievement for the total of 239 inmates of the institution was 8.6 grades, while the average grades completed by the 56 drug users was 10.8 years. Obviously, offenders who have become addicted to narcotics are not just dumb women who would be expected to have an inferior understanding of the complexities of urban life. These women have spent a period of their lives in the public school system.

Among the 56 inmates of our study, 29, or 51.7 per cent, are married. Of these married inmates, 13, or 23.2 per cent, were separated from their spouses prior to admission to the institution. The remaining 40, or 71.4 per cent, fall into marital categories as follows: seven, or 12.5 per cent, are divorced; six, or 10.7 per cent are widowed; 14, or 25 per cent are single. The widowed, divorced, and single—which compose 71.4 per cent of the group—are indicative of the fact that no stable marital relationship was established among the vast majority of these offenders prior to their commitment to the institution. Of these 56 women, of whom 71 per cent had no established marital relationship, 24, or 31 per cent, were mothers of one or more children. The distribution of motherhood among them, according to marital status as declared by the inmates without verification, was as follows:

Marital Status	*Number*	*Per Cent*
Married	6	1
Separated	12	21.4
Divorced	2	3.5
Widowed	4	7
Single	6	1

It probably is significant and important to the understanding of these offenders' concept of conventional conduct that most of them will readily declare an identification of some degree to a religious belief or faith. Many withdrew from church and religious activities early during the course of their shift from conventional jobs, relatives, marriage, and a life of noncriminality. Nevertheless, there is no significant discernible relationship between the religious faith declared

and the development of addiction and/or criminality as such. However, religion may well play an important role in the re-orientation of the drug addict to the conventional world and the acculturation of the offender in general.

Addiction in the genesis of criminality

Narcotic addiction has been described in many ways, but most authorities on the subject will hold no quarrel or major disagreement with the definition promulgated by Vogel, Isbell, and Chapman:

"Drug addiction may be defined as a state in which a person has lost the power of self-control with reference to a drug, and abuses the drug to such an extent the person or society is harmed. It should be noted that addiction implies a compulsive and repetitious use of the drug, and the harm done the user varies with the degree of personality disorder which characterized the addict. In addition, one or more of the following related and distinct phenomena is always present: 1. Tolerance; 2. Physical dependence with resulting abstinence illness when the drug is withheld; 3. Habituation or emotional dependence."[5]

According to the Diagnostic and Statistical Manual of Mental Disorders, a person who is using narcotic drugs classifies as suffering from a personality disorder or drug addiction which is symptomatic of organic brain disorder, psychotic disorder, or psychoneurotic disorders.[6]

In discussing addiction proneness, Mauer and Vogel point out: "When a person with psychological conflicts, which he cannot resolve in some practical way, or when the chronic psychological or organic distress comes into contact with opiates he may feel that he has formed an attractive solution for his difficulty. If he has an unstable personality, as well as a low tolerance for either physical or mental discomfort, and if opiate drugs relieve this discomfort to the degree of ecstasy and a complete sense of well being, he probably will become a drug addict."[1]

The majority of offenders in this study used marijuana prior to using other more strongly addicting drugs. Maurer and Vogel evaluate the effect of marijuana by saying: "Possibly the most dangerous aspect of marijuana is the fact that it so often, especially among youngsters, leads to the use of heroin. The reason for this cycle of marijuana to heroin or heroin plus cocaine is not yet fully understood beyond the fact that environment and propinquity make for a desire to graduate from marijuana to opiates. It is possible that marijuana in some way conditions the user for heroin."[1]

Although some of the offenders under study used heroin with cocaine, heroin with morphine, heroin alone, or morphine alone, no particular patterns of significance could be related to their social history, modus operandi, or personality pattern. Two of the 47 who underwent intensive interviewing relative to their history of using narcotics, denied ever using drugs. These two offenders who are serving sentences for sale of narcotics readily talked about the criminality of addicts but insisted they had never experimented with drugs on their person. Nine additional offenders admitted using narcotics over a period of at least three months, but vigorously denied having become addicted.

For the inmate population as a whole, drug addiction among white women does not constitute a major quantitative problem, for only six of the 56 drug users were white and three of the six insist they were never addicted. This denial was made on the basis that they never had to undergo withdrawal symptoms at the termination of their use of the drug.

A careful study of 45 of the 52 subjects revealed that they were introduced to using narcotics between the ages of 14 and 42. Since these offenders began using narcotics at the average age of 25, and drug addiction in most cases was not necessarily a matter of juvenile delinquency, drug addiction among these offenders is mainly a practice entered into during early adulthood. Of the 44 cases studied, only eight, or 1.8 per cent, were under the age of 18 at the time they started using narcotics. The average offender studied proved to have been a drug user for a period of about three and one half years. Of 38 cases subject to careful study to determine the reason for withdrawal of drugs, 12 underwent withdrawal without being arrested while the other 26 admitted that they underwent withdrawal while being detained in jail for one purpose or another. On the other hand, 14 other offenders also had undergone withdrawal without being arrested, notwithstanding the fact they had at other times undergone withdrawal while under arrest. These facts may indicate that most of the 26 offenders of the 37 studied desired to

reform and attempted to do so at one time or another. Such efforts are suggestive of the fact that such attempts, although failures, may be an index of the offenders' amenability to therapy and rehabilitation. The average offender underwent withdrawal either as a result of arrest or self-discipline twice during the course of her period of addiction. When questioned as to circumstances and persons associated with her induction as a drug user, the offender replied as follows:

1. She couldn't sleep after the death of her father, and a friend (male) gave her some heroin.
2. Her identification with her peer groups engendered her curiosity regarding herself after observing other members of the group shoot the stuff; so she took the initial injection with a sense of bravado.
3. A fellow worker who was addicted (male) kept telling her how fine it was. After she was hooked, he introduced her to his pusher.
4. Boy friend addicts frequently gave the stuff to them to sniff or snort when they had a headache, menstrual cramps, or other minor physical discomforts.
5. Husband introduces her while she was faking illness to keep from participating in sexual intercourse with him.
6. She had observed an older woman friend.
7. A fellow worker who was addicted under medical supervision.
8. Heard about it and sought out a supply.
9. Sold drugs for several months and then began to try it herself.
10. Offender was completely at a loss to account for when and where she started.
11. Relative other than husband.
12. Met some girls in county jail who used drugs.

In every case, the friend who introduced the offender to the drug was an addict. Often, the offender stated that she didn't know that her boy friend was an addict until after she was addicted.

Personality characteristics

The supply of the drug is of fundamental importance to an addict. As one prostitute stated to the writer, when being queried as to whether or not there was a pimp involved in her early beginning of prostitution, replied: "I didn't have time for any men except those in my trade. The only pimp I had was the junk and that monkey was on my back." When questioned as to how they acquired their daily supply of from two to 10 grains of morphine or heroin per day, with an injection or fix lasting from four to six hours, the offenders replied that their husband or boy friends, who often were addicts and peddlers, supplied them. The earnings of their husbands or boy friends, which often came from criminal sources, and the paramount factor—the efforts of their own criminality—either started or was greatly increased after they had become addicted. The supply, and the $25 or more per day which it cost to purchase it, had priority over everything and everybody, including the welfare of the addict herself. The obsessive compulsion to assure the supply of the drug is reflected in the fact that the addict can give no reasonable account of the cost of the drug per day, but is able to talk only in terms of the amount needed. Such an addict also could reply with words to the effect that she earned as much money as she could doing anything, as it took all she could get to get the stuff.

When inquiry was made of the offenders as to why people become addicted, their answers usually were not well formulated. Such answers usually were as follows:

1. People are weakminded.
2. People are weak.
3. Curiosity.
4. As an outlet.
5. For a thrill (bravado).
6. Bad associates.
7. Poor judgment.
8. Nerves.
9. Mixed up.
10. Depressed.

Although the answers enumerated above indicate some small degree of insight relative to the underlying instability or neurotic condition of an addiction prone personality, there is a strong flavor of flightiness and monosyllabic communication which cannot be ascribed to the inability of these offenders to express themselves adequately. The efficiency with which these offenders are capable of articulating and interpreting ideas is indicated by the fact that they have an average amount of formal education, commensurate with persons of their age and sex group. They also

have enjoyed additional experience in composing an argot which is used in their day to day dealings with narcotic users and handlers. The addict feels guilty and ashamed in reference to the habit and reacts emotionally rather than rationally to any etiological query relative to anyone's addiction and thus, by easy identification, her getting hooked.

The responses to a request for any additional remarks regarding addiction also were lacking in insight. There were such responses as: "It certainly caused me a lot of heartaches; I wouldn't advise anyone to try it."

To some degree, the last two responses embrace social responsibility and personal integrity, but most offenders responded in a manner that was lacking in a workable philosophy for the present and any rational plan for the future.

Factors affecting criminality

Usually when drug addiction and criminality are each a phase of the same discussion, the old question arises as to which comes first, the chicken or the egg. Is the offender first an addict and then a criminal or is the offender a criminal who becomes an addict?

In the formulation of a hypothesis for the analysis of criminal conduct among addicts we observe factor number one: Addiction established late in the criminal career.[7] Such an addiction may be explained by the fact that this particular criminal has undergone a traumatic experience that has left him vulnerable to the suggestions of others who are addicted to drugs or who are peddling narcotics. In this study, one such offender became addicted who sold narcotics professionally and began to use drugs as a pick up for the first time after having had ready access to narcotics in practically every form for over 15 years. The daily associates of the professional criminal make narcotics available at any time; although he may not be a junky, there is an element among his continuous social contacts which is always ready to make him one.

Factor number two: Professional criminals reject association of addicts. Any professional criminal who resides in an urban community is a nonaddict by choice and in no sense free from addiction for want of opportunity. Those who participate in the day to day activities of the criminal community are well aware of the softly asked, "What do you know?" and "What are you putting down?" is more often than not the junky asking his man if he has got any stuff with him.

We also have evidence among our 56 offenders who, for example, were prostitutes but were denied the opportunity of practicing the better houses because they were considered a double threat; e.g., the house might not only get raided because of prostitution but the local narcotic squad might also conduct an investigation as might the Federal Narcotics Bureau, or any other police agencies that concern themselves with narcotics but not with prostitution as a form of criminality. However, this second category (professional criminals reject association of drug addicts because of instability) is a negative factor in its relationship to precipitating crime among addicts. The exclusion of addicts by professional criminals apparently is more of a deterrent to crime among addicts than it is a contributing factor to criminality.

Factor number three: Addicts commit crimes to get money with which to purchase drugs. This factor was common among our 56 offenders. We may deduce that old offenders with well developed criminal careers may — as a result of change in emotional adjustment — succumb to the ever present offer of the pusher. We may well conclude with a preponderance of evidence that addicts commit crimes to get money with which to purchase drugs.

Among the 56 offenders of this study, 30, or 53.5 per cent, are serving sentences for committing offenses in violation of the Uniform Narcotic Act.[8] Offenders among drug users who committed acts in violation of the Uniform Narcotic Act constitute 12 per cent of the total number of 239 offenders. Besides these offenders of the Uniform Narcotic Act, there are 10 other such violators who have never used narcotics in any form. Other than offenses against the Narcotic Act, these 56 drug users have no greater tendency to commit other offenses than do the remainder of the 239 inmates. As a matter of fact, the 56 drug users committed less murder, manslaughter, and assaults in general.

According to the Federal Bureau of Investigation's fingerprint file, these 56 offenders have received an average of three sentences, inclusive of the one they are now serving. Fifteen of the 56 are first offenders. Of these 15 first offenders, nine, or 80 per cent, are violators of the Uniform Narcotic Act. Although these offenders

have served an average of three sentences for offenses inclusive of the one they are now serving, they have been arrested an average of nine times during the course of their adulthood. As juveniles, 18 are know to have gone before the Juvenile Court and five of these 18 were committed to the Illinois State Training School for Girls at Geneva, Illinois. None of these juvenile experiences was related to the use, possession, or sale of narcotics.

The crimes for which the 56 offenders of this study are now serving sentence are:

Offense	*Number*	*Per Cent*
Uniform Narcotic Act	29	51.8
Confidence game	5	8.9
Larceny	8	14.2
Receiving stolen property	1	1.7
Burglary	2	3.5
Robbery	9	16.0
Assault with attempt to commit robbery	1	1.7
Murder	1	1.7

Although the statistical audit of the offenses committed by the 56 offenders under scrutiny is accurate, it should not be concluded that the distribution of these offenses would be the same among addicts in the extramural community. Confidence games in particular are practiced much more widely among addicts than is indicated in the 8.9 per cent characteristic of the incarcerated population under analysis in this study.

Clinical criteria for criminality

All 56 verified case files were analyzed in reference to 14 factors relative to their personal and social histories. Supplementary to the information secured from the case files, the inmates were interviewed in reference to the 15 basic factors believed by the Gluecks to be related to future delinquency patterns.[9] This interview material also was checked against verified case file data.

In addition to the aforementioned evaluations, all data on the 56 offenders were subjected to the Illinois Experience Table as developed by Ohlin.[10] Although the validity and reliability of this experience table were established for male offenders only, the table, with some allowances, may be applied to female offenders.[11]

According to the adjustment of the data of our study to this experience table, all of the 56 offenders are reasonable parole risks, for their critical score falls above minus three and minus four where more than 50 per cent of the cases will be violators. Only one case falls into the lower category, and it falls above the critical score.

The adjustment of these data to the experience table indicates that as a group, the 56 offenders under scrutiny in the study would be reasonably good material for clinical treatment in reference to their criminality. As it has been observed that drug addiction tends to be the predisposing factor in the development of criminality among these offenders, it is the drug addiction that should be treated. It also has been observed that drug addiction among these offenders is largely the precipitating cause of their criminality in that their criminality is mainly for the purpose of supporting their addiction.

Constructive program

Extended incarceration is an advantage in protecting the addict from the situations in the community that are conducive to his return to the use of narcotics. The incarcerating institution in which the addict is to be treated must be absolutely secure from the traffic of narcotics within the institution. Such security necessitates the careful screening of all personnel.

Treatment of the addict must include medical treatment for all physical disease. Individual counseling is fundamental in the treatment of the addict. Group counseling may be conducted but any evaluation made of the inmates' participation in group activity must be done on an individual basis. It also is important that such therapeutic groups should not be composed mainly of addicts. Since addicts tend to withdraw from the community as a whole, reorientation rather than original social learning will be the major objective of either the group or individual counseling.

Since most addicts are not gainfully employed in noncriminal occupations at the time of their arrest, and usually have not been so for quite some time, emotional and educational guidance usually is indicated.

The offender with a history of drug addiction should be released in parole status under the

supervision of a professionally qualified parole officer. In this conjunction, arrangements should be made with the Medical Counseling Clinics of the Illinois Department of Public Health for an appointment immediately upon the addict's release from the institution. This service may be of great assistance in aiding the parole officer in handling the intricate psychological, emotional, and medical problems often attending a recently released addict.

It is reasonable to believe that if a professional program is conducted, with the chief objective of relieving the addict of his addiction proneness, there will be an appreciable degree of success in accomplishing the reduction of criminality among offending addicts.

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Dog sense

There are instances in which a good observer can equal and even surpass an animal in its faculty of "understanding" and anticipating the intentions of its fellow, but in other cases he cannot hope to emulate it. The dog's "receiving set" far surpasses our own analogous apparatus. Everybody who understands dogs knows with what almost uncanny certitude a faithful dog recognizes in its master whether the latter is leaving the room for some reason uninteresting to his pet, or whether the longed-for daily walk is pending. Many dogs achieve even more in this respect. My Alsatian Tito, the great-great-great-great-great-grandmother of the dog I now possess, knew, by "telepathy", exactly which people got on my nerves and when. Nothing could prevent her from biting gently but surely, all such people on their posteriors. It was particularly dangerous for authoritative old gentlemen to adopt towards me, in discussion, the well-known "you are, of course, too young" attitude. No sooner had the stranger thus expostulated, than his hand felt anxiously for the place in which Tito had punctiliously chastised him. I could never understand how it was that this reaction functioned just as reliably when the dog was lying under the table and was therefore precluded from seeing the faces and gestures of the people around it: How did she know who I was speaking to or arguing with? *Konrad Z. Lorenz. King Solomon's Ring. Crowell Publishing Company, 1952.*

The View Box

Franz Gampl, M.D., *Chicago*

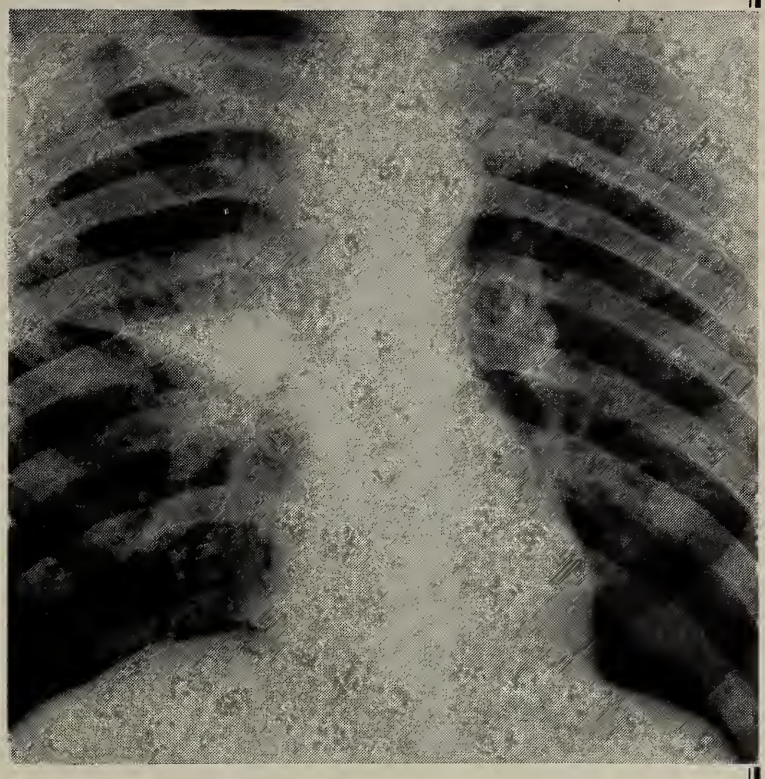


Figure 1. Chest roentgenogram

This 26 year old Negro male complained of cough productive of moderate amounts of yellowish sputum, and night sweats of a few weeks' duration. Three weeks prior to admission he noted some blood streaked sputum on one occasion. He had lost 10 pounds over the past 3 months. Two years previously he was hospitalized for a "bronchitis."

The physical examination revealed a patient who was chronically ill and showed evidence of weight loss. The temperature was 101F., pulse 100/minute and regular, the respiration 24/minute. Blood pressure was normal.

The chest was clear to percussion, but expiratory wheezes were heard over the right anterior chest wall. A few small, non-tender nodes were noted in both groins. No other lymph nodes were enlarged.

The hemogram and the differential blood count were normal. A Mantoux skin test was strongly positive; the histoplasmin test, equivocal. Twenty-four-hour sputums and bronchial aspirates showed no tubercle bacilli on smear. A scalene node biopsy was interpreted as showing nonspecific inflammatory changes.

What is your diagnosis:
- Bronchogenic carcinoma
- Lymphoma
- Tuberculous lymphadenopathy
- Acute mediastinitis

From the radiology department, Cook County Hospital

(*continued on page* 330)

"Learning to know you"

The point here is that we do each live in a subjective island from which there is no escape, and we do often pass each other in a psychological darkness. The inner recesses of our being cannot be known only or even best in groups. This flight from contact with ourselves, which is perhaps the dynamic behind much of our social activity, testifies eloquently to the impoverishment of the Self. The alienated individual has to drown himself in activity to avoid the painful possibility of confronting himself. Fromm advocates, at one point in *The Art of Loving* that we take 20 minutes each day to do nothing. And, paradoxically enough, this period of solitude may help to sometimes disturb but also to illuminate and extend our experiences in our interactions. *Benjamin Mehlman, Ph.D. Love as the Measure of Man. Ment. Hyg. January 1961.*

MEDICINE IN THE OUT-OF-DOORS



Poison Oak



Poison Sumac



Poison Ivy

The Baneful Weeds

Julius M. Kowalski, *M. D., Princeton*

A third of a million persons in this country, having spent several millions of dollars, will still be miserable this summer from poison ivy dermatitis. This finding is as constant as the changing seasons, and the figures will rise as more Americans take to the out-of-doors with increased leisure time. The lone hope for a reversal lies in preventive medicine, specifically, recognition of poison ivy, poison oak, and poison sumac, and avoidance of contact.

The great variation in morphology of these plants and location of their growth makes the unsuspecting individual an easy victim. The degree of skin involvement is dependent upon the exposure dose — slight, moderate, or severe — the length of exposure, the condition of the skin at the time of exposure such as dry or sweaty, abraded or injured from sunburn or insect bites. Darwin cited his study of finches to demonstrate variation and adaptation. He could have done as well in illustrating poison ivy and its relation to human skin disease.

The skin of children invariably is more susceptible than that of adults. Usually more of the body area is involved because of the manner of dress of youngsters in warm weather. Farmers, utility men, foresters, and others who come in frequent contact with the plant acquire a certain degree of immunity. This may not be a true immunity as acquired after illness with a communicable disease since true antibodies are not demonstrable by usual technics. More likely, this supposed immunity is due to a constant awareness — the ability of these individuals to avoid contact on the basis of painful past experiences by using protective measures. Also, older cornified skin is usually less permeable to contactants. Those especially sensitive individuals experiencing many severe reactions would not continue in such occupations.

No description of plants, no matter how detailed, can take the place of field trip observations. Museum, as well as high school and college botany departments, are likely places for first acquaintance. The conscientious greenskeeper of a golf course can be a source of fairly reliable information as well as farmers and persons engaged in pursuits which take them frequently into woodlands and fence rows. Poison ivy and poison oak go under a variety of local names. The plants' great adaptability and foliage variation easily leads to confusion in classification by amateurs. Poison ivy is found in all parts of the United States and southern Canada; poison oak is found primarily south of the Ohio River and from central Oklahoma and Texas eastward. Another subspecies of poison oak grows in the three Pacific coastal states. The plants are found as erect woody shrubs, as trailing shrubs growing close to the ground, and as woody vines clinging to trees, taller shrubs, and posts for support. They grow in the shade of thick woodlands,

in moist, humus soil, as well as on sunny hillsides in sandy soil. They are most often found along fence rows, pathways, and climbing over rock piles and fences.

A characteristic finding is that the leaf always consists of three leaflets, and stems and twigs are thornless. Therefore, the jingle heard in many children's summer camps: "Leaflets three, let it be; it's poison ivy." The individual leaves may be 4 to 14 inches long as they arise from the twig, and the individual "leaflets three" may measure from 2 to 7 inches in length and 3 inches wide. They may be stiff and leathery, or paper thin. The margins of the leaflets are often smooth, but on the same plant some may be toothed or wavy-edged. In the spring and again in the fall, the leaf color is reddish or of varying shades of brown, but in midsummer they are most often a shiny deep green. The poison oak variety, which is in no way related to the oaks, possesses all of these characteristics, but the leaflets tend to be broader and their edges are invariably notched, resembling individual oak leaves. Gall formation on the leaflets from insect infestation is responsible for wart-like protuberances often found on them.

The fruit of these three poisonous plants is similar in that it is white, shading from green to cream, shiny and waxy like mistletoe, and each seed is segmented from pole to pole much like a minature muskmelon. Seeds vary from 1/8 inch to 3/8 inch in diameter, and they grow in clusters immediately above the juncture of the leaf stem to the parent twig. It is at this point that whitish flowers appear in clusters earlier in spring; an individual flower with its five petals measures about 1/4 inch in diameter. Many species of birds eat the fruit of these poisonous plants and thereby help disseminate them. This is the explanation offered for finding the plants away from their usual environment.

All parts of the plants contain the nonvolatile phenol-like substance *urushiol* — leaves, twigs, flowers, seeds, and roots. This is the contactant responsible for dermatitis. It clings to clothing, footwear, tools, and the fur of dogs and cats for extremely long periods, which explains the mysterious recurrences of skin lesions weeks after an outing in the woodlands. In the process of burning these plants, the oil is mixed in with the smoke and light ash and can be carried through the air for considerable distances.

Poison sumac is found almost exclusively east of the Mississippi River. It never grows as a vine like ivy or oak, but as a shrub or small tree ranging from 5 to 25 feet in height. Its habitat is restricted to wet acid soils, therefore in or near swamps and marshes for the most part. However, occasional isolated plants are found on high, dry land; invariably then, the shrub or tree will be small.

The striking feature of the leaves, ranging in size from 6 to 12 inches, is that they consist of 7 to 13 leaflets in pairs along the stem, and there is a single terminal leaflet. Their shape is an elongated oval with margins smooth. There is never any variation to a wavy or toothed margin on these leaflets as is found in other innocuous sumacs. Their size most often is 3 to 4 inches in length and 1 or 2 inches in breadth. In spring and fall the color is an appealing bright orange to deep red, which traps the unwary leaf collector. In midsummer, the leaves become glossy, dark green with reddish mid-ribs. The flowers appearing in spring arise on long slender stalks and are attached to the main twigs just above the junction of the leaf to the parent twig. Most often they are a shade of yellow green. These mature to greenish-white fruit hanging in loose clusters which may be up to 12 inches in length.

The above characteristics distinguish poison sumac from the three other varieties of sumac which are widespread in this country. In addition, the three harmless species have small red seeds on dense spikes at the ends of the branches. They have been used extensively by some highway and railroad personnel to control erosion on steep banks, and the deep red coloration of the leaves in fall is eye-catching.

The treatment of the dermatitis resulting from contact with this pernicious ivy, oak, or sumac is easy — execpt for the patient, especially children. Severe itching, burning, extensive involvement, or any lesions about the body orifaces can be brought under control with corticosteroids. But much discomfort could be ameliorated or made nonexistent if only one was always aware of these plants, knew what to look for, and avoided the weeds.

The View Box—diagnosis and discussion (*continued from page 327*)

The plain chest roentgenogram and the laminogram reveal large, smooth noncalcified hilar lymph nodes compressing the right main bronchus and the bronchi to the right upper lobe, causing atelectasis of the anterior segment of the right upper lobe. Although the preoperative diagnosis of tuberculous mediastinal lymphadenopathy was entertained, an exploratory thoracotomy was done.

Large lymph nodes were found at the right hilus and along the superior vena cava. These exuded creamy pus on cut section. The histologic examination revealed chronic lymphadenitis with necrosis compatible with tuberculosis. Cultures of the bronchial aspirate and the lymph node exudate revealed *Mycobacterium tuberculosis.*

Unilateral, non-calcified mediastinal tuberculous lymphadenitis is uncommon. The differentiation from mediastinal tumors and the malignant lymphadenopathies is difficult. Certain findings, however, lend themselves to establish the nature of this entity. Negroes, American Indians, Fillipinos, and Puerto Ricans have a higher incidence of tuberculosis than the average population. The age of the patient in the second and third decade and the history of "bronchitis" or pleurisy are helpful clues. A negative tuberculin skin test makes the diagnosis unlikely. The location of the smooth, spherical, sharply circumscribed tumors of homogeneous appearance or with central calcification in the right upper mediastinum, often impinging upon the transverse portion of the azygos vein and the superior vena cava, the trachea, and the central portions of the bronchial tree, are further diagnostic aids.

In the absence of cultural proof of the tuberculous etiology early exploration is mandatory.

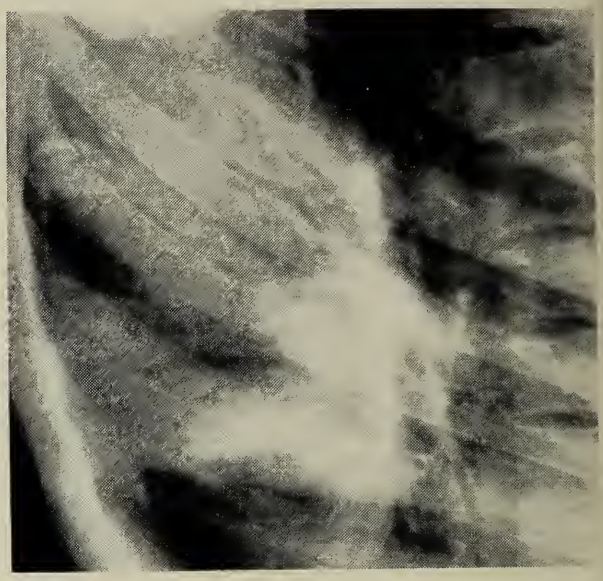


Figure 2. Lateral chest roentgenogram



Figure 3. Laminogram

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Co-operation is spelled with two letters—WE.— *George M. Verity*

Trifluoperazine* in the Treatment of Withdrawn Catatonics

Rochus Stiller, M. D. (**) and Jacob Glotzer, M. A. (***), *Elgin*

Although during the last few years great progress has been made in the application of chemotherapy in the treatment of mentally ill patients, most of the advances were in the management of the hyperactive psychotic, or in the resolution of the turmoil of neurotic and other depressions. Remaining still are the great number of withdrawn schizophrenics who populate the so-called "back wards" as chronic, and often lifelong, inhabitants. It is these who, because of their negativistic attitudes and regression to lower stages of adjustment, remain a source of great concern to every ward physician and hospital administrator. Rudy et al.[1] and other investigators[2-9] had used trifluoperazine successfully in the treatment of various psychiatric disorders.

From Jan. 1 to Oct. 1, 1959, we undertook at Elgin to evaluate the treatment response of 80 withdrawn catatonics, refractory to many other treatments.

All other patients were continued on intramuscular medication. They showed no local adverse reactions to the prolonged use of injectable Stelazine®. The oral drug was administered by psychiatric aides on the ward, and all intramuscular medication by an especially assigned psychiatric technician.

Side reactions

There were 37 cases of parkinsonian-like tremors, stiffness of the neck, arms and leg muscles, shuffling gait, general weakness with pill-rolling movement of the fingers. Oculogyric crises occurred in 4 cases. Restlessness, insomnia, hyperkineses, and inexplicable fears were evident in 45, and there were 34 cases of salivation, drooling, excessive sweating, or dryness of the skin.

It should be noted that many patients experienced more than one kind of side reaction. These usually occurred early in the treatment and at small dosages, while other patients showed no side effects regardless of what dosage was used. Side reactions were treated by temporary discontinuation of medication, reduction of dosage and a slower rate of increase, or antiparkinsonian drugs (Artane®, Cogentin®, Rabalan®). We preferred to use these adjunctive medications sparingly.

The age of patients ranged from 18 to 54 years, with an average of 36 years. They had been hospitalized from 1 to 28 years, an average of 10.5 years. Previous treatment had been electro-shock — 66 patients; insulin coma — 25 patients; other treatments — 65 patients. Sixty had received Thorazine®, and 5 patients had other medications, with negative results.

Method

For the first three months we used only intramuscular trifluoperazine given twice daily. The dosage, adjusted to the individual's response, ranged from 4 to 25 mg. per day, the average being 10 to 20 mg. At the end of three months, patients who would accept oral medication were given tablets in the afternoon; injections were continued in the morning. Oral dosage ranged from 5 to 50 mg. per day, with an average of 20 to 40 mg. When their cooperative attitude was established, these patients were then changed to oral medication twice daily.

Results

Improvement was noted in 47 patients (58%). Of these, 13 patients have been discharged from

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*Trifluoperazine *(Stelazine) was furnished gratuitously by the Smith Kline and French Laboratories in Philadelphia.*

**Staff Psychiatrist, Elgin State Hospital, and the department of psychiatry, The Chicago Medical School.*

***Staff Psychologist, Elgin State Hospital.*

Read before the Physicians' Association of the Department of Public Welfare meeting in conjunction with the Illinois Medical Society, May 26, 1960.

the hospital, 7 at the end of the treatment period and 6 others since then. Eight patients are awaiting discharge, but because of their long hospitalization we have found it difficult to remobilize the involved relatives. Twenty-six patients became more alert, became more manageable, their appetite increased, and they were beginning to utilize the recreation facilities.

Unimproved were 23 patients (28%). Their illness apparently was fixed and encapsulated. Deterioration was seen in 4 patients (5%). In these, their awakening produced a symptomatology that affected the ward routine adversely. The reappearance of former personality traits long submerged by their catatonic illness reappeared. Two of these patients exhibited definite Lesbian tendencies. Six patients (8%) were lost to the study. One of these died of an illness that required her transfer to the General Hospital, and the others were lost by transfer to other institutions.

Summary and conclusions

Trifluoperazine was given over a 9-month period at the Elgin State Hospital to 80 female patients with an average hospitalization of 10.5 years. It proved extremely useful in regressed and withdrawn catatonics refractory to other therapies; 58 per cent of the patients treated with trifluoperazine improved, with 26 per cent being discharged or ready for discharge.

Intramuscular therapy for as long as three months, and even longer with some members of the group, resulted in no complaints of undue pain or discomfort at the site of the injection.

In general, the patients tolerated the treatment well, although a great number of them did show side reactions involving the extrapyramidal or autonomic nervous system. These reactions usually occurred early in the course of therapy and at low dosages, but management was not difficult in a hospital environment. Patients who showed no sensitivity at the beginning of therapy seldom had side reactions regardless of the dosage used. It has been our experience that often those with the most severe side reactions also showed the greatest treatment response. Therefore, treatment once started should not be terminated too early.

Slight fluctuations in blood pressure were noted with trifluoperazine, but these were of no clinical significance. There were no hypotensive episodes.

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Urine specimens without catheterization

A plea is made for the abandonment of routine catheterization to obtain specimens of urine for culture from women, and a case is presented to show that satisfactory mid-stream urines can be obtained without too much trouble. It is claimed that the 74% satisfactory mid-stream specimens taken from men and the 72% from women justify this claim and that these figures compare very favourably with the respective figures for catheter specimens—93% in men and 85% in women. The investigation also demonstrates the disadvantages of delay in initiating the culture, especially in mid-stream urines from women. It is hoped to minimize this with refrigeration, and a further series will be carried out with this end in view, for it may not always be possible to get the urine cultured on the day the specimen is taken. *S. H. C. Clarke, F.R.C.S. Investigation into Methods of Collection of Urine for Culture From Men and Women. Brit. M. J. Nov. 19, 1960.*

Treatment of Inflammatory Conditions

Of Muscles and Joints with Delenar®

Stanley E. Anderson, M.D., *Rockford*

The pain, inflammation, and functional disability of arthritic disease usually are dramatically reduced by treatment with corticosteroids; however, because of the possibility of side effects, most physicians hesitate to administer full therapeutic dosage of a steroid for extended periods of time unless the disease is far advanced and the patient is severely handicapped.[1] In mild and moderate cases of inflammatory disease or trauma of the joints or muscles, it is preferable to administer very low doses of a steroid and supplement its effect with salicylates and muscle relaxants. Combinations of a small amount of steroid and other agents for symptomatic treatment may be needed for mild and moderate cases. One preparation incorporates the efficient steroid, dexamethasone.

Pharmacology

Each tablet of Delenar contains 0.15 mg. dexamethasone, 15 mg. orphenadrine hydrochloride, and 375 mg. aluminum aspirin which breaks down in the gastric juice to 300 mg. aspirin and 75 mg. aluminum hydroxide.*

Dexamethasone is a synthetic analogue of prednisolone in which addition of fluorine at the 9-alpha position and a methyl group at the 16-alpha position increased the milligram-for-milligram anti-inflammatory potency to seven times that of prednisolone and approximately 30 times that of hydrocortisone.

Orphenadrine hydrochloride, an α-methyl derivative of the antihistamine diphenhydramine, reduces rigidity, tremors, and contractures of the voluntary muscles. Animal experiments reported by Cronheim[2] indicated slight antihistaminic but pronounced antitremor activity. The drug is used as ancillary therapy in paralysis agitans to increase functional ability by reducing muscular rigidity and tremor. It may also provide some relief of musculoskeletal symptoms in multiple sclerosis. Finch has reported good results with orphenadrine hydrochloride, 150 mg. daily, in diminishing muscular spasm associated with pariarticular inflammation: rapid symptomatic relief in 87 per cent of his 104 patients[3].

Aspirin is, of course, universally used for analgesia. Several studies[4] indicate that it may synergize with a corticosteroid and therefore be especially useful in treating inflammations affecting the muscles and joints.

Methods

Delenar was used to treat 30 patients with acute inflammations of muscles and joints or with exacerbations of chronic inflammatory disease. Their ages ranged between 30 and 72 years; the mean average was 53 years. Hypertension, arteriosclerosis, or other vascular disease was present in seven patients. The duration of treatment was 1 to 12 weeks. Dosage was started at 2 tablets three times daily and was reduced after one week to 1 tablet four times daily.

Twenty of the 30 patients had been treated previously with other antiarthritic preparations such as cortisone, gold, phenylbutazone, vitamins, salicylates, and prednisolone alone or combined with meprobamate or salicylates. In these patients we attempted to evaluate subjectively and objectively any differences in response between previous and present therapy Except that penicillin was prescribed for a patient with pharyngitis, no other drug was used during the trial with Delenar; a few patients received ultrasonic or direct-heat treatments.

**A few patients were treated with a preliminary experimental compound containing 300 mg. aspirin and 100 mg. aluminum hydroxide. This formula was revised for stability reasons but is clinically indistinguishable from the present drug. The compounds were provided for clinical trial by Schering Corporation, Bloomfield, N. J.*

TABLE 1—Indications and Results.

Diagnoses	Number of Patients	Results: Complete Relief	Improved	No Relief	Weeks of Treatment
Rheumatoid arthritis	7	6	1	-	1-8
Rheumatoid arthritis with disc syndrome	1	-	1	-	2
Rheumatoid arthritis with osteoarthritis	3	2	1	-	6
Traumatic arthritis	3	3	-	-	1½-4
Calcific bursitis	2	1	1	-	1-1½
Disc syndrome	4	2	-	2	1-1½
Myositis with fascitis	1	1	-	-	1
Osteoarthritis	5	1	4	-	1-12
Tendinitis	1	1	-	-	1½
Tendinitis with calcific bursitis	1	1	-	-	1
Tenomyositis	2	1	1	-	1½-2
Summary	30	19	9	2	Mean: 2½

Results

The results of treatment are summarized in Table 1. Complete relief of symptoms occurred in 19 patients and 9 improved to some extent. Two patients failed to benefit. The drug appears to be especially effective in acute exacerbations of rheumatoid arthritis, in traumatic arthritis, and in acute soft-tissue inflammations. It is effective, although to a lesser extent, in osteoarthritis and for pain associated with the disc syndrome.

A male had severe osteoarthritis of 18 years' duration. The hips, back, and feet were extremely painful. This patient also has a large ventral hernia and chronic sinusitis, and had had a hemicolectomy. The dosage of Delenar was 2 tablets three times daily (0.9 mg. dexamethasone daily), and there was a rapid favorable response. The drug was continued for three months. The patient rates himself 90 per cent improved; the skeletal system appears to be almost free from pain and disability, and there is a general feeling of well-being. Great improvement is evident objectively also. There has been no clinical side effect, and weekly urinalyses have yielded consistently negative results.

A female with chronic rheumatoid arthritis had previously been treated with every known drug available for the disease. She had obtained the best results with cortisone, but eventually deteriorated to the point where she could no longer work. With no expectation of dramatic results, we administered Delenar. The patient had complete relief of symptoms for the first time in many years and is considering returning to work.

In a patient with osteoarthritis there was some improvement during the first week of therapy, but this did not continue during subsequent administration of Delenar nor, later, with dexamethasone alone.

An emotional component tending to prolong disability was recognized in one of the patients with a disc syndrome who failed to benefit and also in a patient with calcific bursitis who had only moderate improvement.

Eighteen patients stated that Delenar gave relief superior to that with previous therapies and two believed that the newer drug was equally effective; no patient stated that Delenar was inferior to a previous drug.

Delenar is tolerated very well. There was no drowsiness, numbness, or diplopia, and no adverse effect on the blood or urine. There were no clinical side effects except in one patient who reported nausea; however, she preferred to continue with the drug because of the excellent relief of pain and disability.

Conclusions

Delenar appears to be at least as effective as any of the presently available drugs for the treat-

ment of many types of inflammatory arthritic and soft-tissue disease and trauma. There is also a mildly euphoric effect, which is desirable, and good muscle-relaxant activity. Since marked clinical improvement can be obtained with low doses of the components, it is likely that they set synergistically.

Summary

Arthritic and soft-tissue inflammations in 30 adults were treated with Delenar, a combination of dexamethasone, orphenadrine hydrochloride, and aluminum aspirin. The initial daily dosage was 6 tablets (0.9 mg. dexamethasone and 90 mg. orphenadrine), usually reduced after one week to 4 tablets daily. Treatment was rarely continued beyond the third week. Complete or substantial improvement occurred in all but two patients and there were no significant untoward reactions.

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CA of the tongue

A study was made of 217 patients with carcinoma of the tongue who underwent some form of dissection of the neck at the Mayo Clinic. This series included 152 men and 65 women, with an average age of 55 years and an average duration of symptoms prior to operation of nine months.

The lesion was a squamous cell carcinoma in 98 per cent of the cases. A total of 91 patients had histologic metastasis; this was on the same side as the primary lesion in 85 patients, and on the opposite side in six patients, with bilateral metastasis in two of the 91 patients. The carcinoma recurred in the tongue in 24 per cent of the patients and in the cervical lymphatic tissues in 41 per cent. Three-fourths of these recurrent tumors appeared in less than one year. A total of 59 patients (27 per cent) lived for five years or more after operation.

These data suggest that a more aggresive surgical approach should be directed toward the primary lesion in the tongue and that radical dissection of the neck more often should be part of the definitive treatment. *Stanley W. Henson, Jr., M.D., et al. Carcinoma of the Tongue. Rocky Mountain M. J. January 1961.*

Maintain your dignity

The so-called crisis in American Medicine is not nearly as great as our critics would have the people believe. A great profession with strong traditions cannot change suddenly—particularly when opposed by politicians whose philosophy is contrary to maintaining for America the best medical care on earth.

There are many projects upon which we are embarked for improving medical education and practice, and others are in the making. We shall continue our efforts to attract more and better doctors into the profession, maintain the dignity of general practice, perpetuate the hospital construction program and apply the free enterprise system and free choice of physicians. Research in our own and ancillary institutions will, of course, continue.

Let us not forget the relatively minor, but not inconsequential, personal obligation to our patients, our profession, and ourselves: We can maintain a dignified and high type reception room with a choice of reading material not inimical to the best interests of our patients and survival of the best medical practice in the world. *Editorial. Crisis in American Medicine? Rocky Mountain M. J. March 1960.*

Lawyers, Physicians, and the Court

Judge Charles S. Dougherty, *Chicago*

For sometime past, the finger has been pointed at Chicago and Cook County because of the backlog of cases in the Circuit, Superior, and Municipal courts, and to the uninformed it would appear, at least from the public press, that we stood alone in this unique situation. This is not true. In fact, in each judicial circuit encompassing urban communities, and including the various circuits of the federal courts, the same condition prevails; each has an individual problem of the mounting caseload.

It gives little comfort to those of us who are charged with the responsibility of disposing of this large volume of cases to know that other courts are in the same boat with us, but we look forward hopefully to the day when sufficient judicial man-power and facilities are provided by the Legislature. Very little headway can be made in the disposition of cases until this situation is corrected. There is a responsibility not alone on the courts in this matter but also on the lawyers and litigants, and there are some things that can be done that will expedite the disposition of some of these cases.

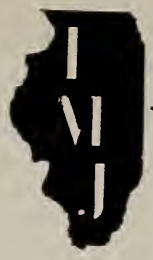
While the record disclosed that there are 40,000 or more cases pending in Cook County, comparatively only a few of these cases will ever be tried by a jury. But these jury cases are time-consuming, and it is in the disposition of this kind of case that the medical profession can be of greatest help to the trial courts.

It is easy to understand why in the trial of these cases there is a lot of lost motion. Most of the cases scheduled for trial on the jury calendar are several years old, and the lawyers for both plaintiff and defendant sometimes have a difficult time rounding up witnesses. After the trial has commenced and some witnesses have been heard, it is not unusual for the court to suspend operation at times for hours awaiting the appearance of a necessary witness. This condition should not be permitted to obtain, and a greater cooperation by the parties involved could speed up a trial of this type.

Some of the principal offenders in this regard are the medical witnesses. I know that in many instances the failure to have the physician in readiness to testify is due to failure of the attorneys to call the witness and to make proper arrangements for his appearance in court, so that the physician can plan his day with the least disservice to himself and to the court. But only too often a delay is occasioned by the medical witness who blithely assumes that the 10 a.m. appearing on most of the subpoenas served upon him means any hour that is convenient to the witness.

Physicians should be assured that both lawyers and judges are willing and anxious to make proper arrangements to the end that no unnecessary time be lost by the witnesses, and that every effort will be made to enable them to give their testimony and return to their duties without undue delay. I am certain that if there is better cooperation between lawyers, doctors, and courts, a great deal of time will be saved in disposing of jury cases with great benefit to all concerned.

EDITORIALS



Patients or people

A group of physicians were examining a rash on a middle-aged woman and making comments on the etiology and diagnosis. The patient raised her head and said, "And don't forget there's a person under that skin."

The scene changes to a courtroom where a lawyer asks the expert medical witness, "Tell the court what doctors think about this condition." The expert shifted his weight and replied, "Well, most people are of the opinion . . . " "Stop!" said the lawyer. "I know what people think. I want to know what doctors think."

The physician again shifted his weight and looked at the judge, "But doctors are people, your honor." And he was allowed to proceed.

We are people. We should recognize this in our patients, and they will reciprocate.

Viral hepatitis

Over 41,000 cases of viral hepatitis were reported in the United States during 1960 according to the U.S.P.H.S.[1]. We can only guess at the true number but it is well known that reporting, even of icteric cases, is far from complete and, furthermore, the incidence of unrecognized non-icteric cases may reach 90 per cent or more of the total. The total number of diagnosable cases was probably between 200,000 and 400,000. The significance of this figure lies in the fact that chronic progressive liver disease can almost certainly follow the milder non-icteric forms of viral hepatitis, as well as the more severe cases with jaundice. Furthermore, since most patients with non-alcoholic and presumably post-hepatic cirrhosis fail to give a past history of jaundice, this neglected group appears to be largely responsible for this complication. Lack of treatment because of failure to make a diagnosis is probably an important factor.

The diagnosis of non-icteric viral hepatitis is always difficult and uncertain except during real epidemics because of the lack of specific tests. A high degree of suspicion is the first essential. The history and physical findings are of course important and occasionally are even diagnostic, but it is always best to have confirmatory laboratory evidence. Bilirubinuria, elevation of alkaline phosphatase and serum globulin, and especially transaminase or other similar enzymes, constitute the most reliable findings. Too much confidence must not be placed on slight to moderate elevation of the flocculation tests, particularly when these are the only abnormal laboratory findings. Specific diagnostic procedures must await the isolation and culture of the virus in the laboratory.

Although treatment is essentially supportive in character, there is ample evidence of its effectiveness. Fluids should be forced, the diet should be adequate, and as few adjuvants should be used as possible. It is most important to avoid narcotics, and as far as possible, all forms of sedation. Concentrated vitamins, antibiotics, and steroids are contraindicated in the average case. Finally, restriction of physical activity is, in our experience, perhaps the single most important therapeutic measure. Although some difference of opinion exists concerning this point, we believe that it is largely a question of the degree of restriction. We believe that relatively strict bed rest is advisable during the period of rising icterus or roughly during the first two to three weeks of the disease. Once convalescence has commenced, this can be modified depending upon such circumstances as the age of the patient and the severity of the acute attack. Failure to abide by the above principles of treatment will, in our experience, frequently result in prolongation of the illness, and occasionally, in the development of chronic progressive liver disease.

Richard B. Capps, M.D.

[1]*Medical World News, Jan.* 20, 1961, *p.* 22.

Immunize against polio

The commercial anti-poliomyelitis killed vaccines have been improved within the last few years. Melnick et al[1] recently concluded that we still have poliomyelitis because vaccine is not administered to susceptible persons. They found that only three of 100 laboratory-confirmed paralytic patients received three or more Salk vaccine inoculations, whereas 87 were unvaccinated and 10 had received either one or two inoculations. In their opinion, "No better results can be expected of any vaccine — either the unactivated one in current use, or the living attenuated one now under consideration in the United States — unless it is fully utilized in the susceptible population."

We should continue to immunize against poliomyelitis despite the previous lack of confidence in the Salk vaccine by many physicians. It was unfortunate that the vaccine was marketed prematurely, and the Cutter incident was a heavy price to pay for haste. Six years have elapsed since the killed-virus vaccine was introduced, and enough improvements have made it the preventive of choice. The oral vaccine will be available this year only for selected projects. Meanwhile our patients must be protected. The new commercial vaccines are stronger than those of 1956-58. A fourth booster shot of this improved 1961 product is recommended for all adults and children who had received the weaker vaccines previously. The usual series of three injections is in order for the unprotected.

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[1]*Melnick, Joseph L., et al. Effectiveness of Salk Vaccine. J.A.M.A., 175:1159 April 1, 1961.*

Cutting the costs

Dr. Harold Margulies of Des Moines recently wrote a timely editorial on health care costs that appeared in the January issue of *Hospitals*. In his opinion, there are ways to reduce medical costs materially.

"Elimination of duplication in medical facilities; reduction in hospital drug costs; control of unnecessary hospitalization and other forms of overutilization of insurance; development of effective home care programs; and centralization of training programs for practical nurses, technicians and other skilled aides."

What are we waiting for?

Illinois camps for handicapped

Elsewhere in the Journal we have listed the Illinois camps for the handicapped. These are geared to meet the needs of youngsters with various types of physical and emotional problems. Camps of this nature usually concentrate on children with orthopedic, visual, hearing, cardiac, metabolic, neurological, and behavior disorders.

Most physicians are sold on the advantages of summer camps, for the normal as well as the handicapped child. It is fun and an adventure that helps the youngster to grow and mature. Our shrinking rural communities make it more important for children to observe the wonders in all that grows and lives in the fields, farms, and forests.

There are few experiences more rewarding to a handicapped child than a few weeks away from home where he lives and plays with children having the same condition. He is taught how to care and compensate for his ailment. The information helps as long as he lives.

The diabetic receives a liberal education on diet, insulin, and the need for repeated examinations to determine whether or not his disease is under control. The same applies to the child with a rheumatic, or congenital heart lesion. Those with cerebral palsy and other crippling disorders are taught to make the best use of what they have. Those with hearing or visual disorders learn also to cope with their disabilities. Facts are substituted for fables, faith for fear.

Most camps rely upon the judgment of the physician as to the advisability of leaving home, and the ability of the child to withstand the rigors of camp living. The sponsors also have their own limitations. This is true of resident and day camps here and throughout the country. Those concentrating on cardiac disabilities, for example, may admit only boys and girls in selected classifications. Those with orthopedic handicaps may admit only the ambulatory, whereas, others will take boys or girls in wheelchairs, provided they are accompanied by an adult. Camps dealing with emotional and behavioral difficulties usually admit children who can be helped and are not of grossly limited intelligence or have severe physical handicaps. Others accept the trainable and educable re-

tarded child who is ambulatory and toilet trained. The physician should be acquainted with the requirements for admission before raising false hopes in the family and child.

Camps for the handicapped are sponsored by a variety of private, public, and philanthropic groups. Some are named after prominent persons; others after the sponsors or donors. One of the camps in Alaska is called "Kuwianewkvik" which means "Place of Happiness." The fees vary from nothing to such ambiguous amounts as "Prices will be increased in 1961."

Resident Camps

In the United States there are 4 camps for asthmatic children; 30 for cardiac cases; 36 for diabetics; 27 for emotionally disturbed children; 13 for epileptics; 3 for those with lowered vitality; 50 for mentally retarded children; 141 orthopedic and neurological camps; 6 for those who are slow to learn; 5 for socially maladjusted children; 45 for those with speech or hearing defects; 44 for those with visual handicaps; 69 which accept children with unspecified physical handicaps.

Correspondence

I believe that the note entitled "Avoiding Malpractice," which was quoted from Russell S. Fisher and appeared in the March 1961 issue of the Illinois State Medical Journal, page 167, is deserving of comment. Item 6 of this article states that tetanus antitoxin should be given in cases involving penetrating wounds even though the patient may have been immunized previously with tetanus toxoid. I believe that this statement should be challenged. It has been thoroughly established that the proper immunization of individuals with tetanus toxoid, followed by booster injections properly given, provides adequate protection against tetanus. In such adequately immunized individuals there should be no reason to give tetanus antitoxin.

Moreover, there are definite reasons for not giving tetanus antitoxin to such properly immunized individuals. A high percentage of patients receiving preparations derived from horse serum will develop a delayed serum-sickness type of sensitivity. While this is generally not serious, it is often disabling, and protracted. In some circumstances this serum-sickness type of allergy may produce serious consequences. The ordinary type of skin tests or conjunctival tests to determine hypersensitivity will not predict the occurrence of the delayed serum-sickness type of allergy. In addition to this type of reaction, a small percentage of individuals may have immediate anaphylactic type of reaction to the injection of horse serum. This type of reaction is extremely serious and may result in death within a few minutes of the time of the injection. In this type of case preliminary allergy skin tests will generally predict such a reaction.

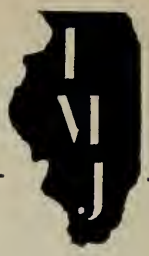
I would feel that patients who are adequately immunized against tetanus and have had properly given booster injections should be considered immune to tetanus and should not receive horse serum. Tetanus antitoxin should be given only to those patients who are deemed inadequately immunized previously. I believe that the routine use of tetanus antitoxin in all patients involving penetrating wounds regardless of the previous immuniologic status will produce many more harmful affects than it will prevent.

Arthur Rosenblum, M.D.

Man asleep

Narcolepsy occurs in patients who are otherwise healthy. Preponderance among men was reported by Daniels; our series is in agreement. However, Yoss and Daly believe that the higher incidence in men than in woman may be because men are more apt to seek treatment for the disability because of social economic pressures. *Gerald Bowling, M.D., and Nelson G. Richards, M.D. Diagnosis and Treatment of the Narcolepsy Syndrome. Cleveland Clinic Quart. January, 1961.*

AT THE EDITOR'S DESK



Pharmaceuticals

Plegine is Ayerst Laboratories' new anorexigenic agent. The formula differs from phenmetrazine and is reported to suppress appetite with a paucity of side effects and a virtual absence of cardiovascular or nervous system complications.

The suggested dosage is one tablet one hour before meals.

Fostril is Westwood Pharmaceutical's new drying salve for acne. It contains polyoxyethelene ether 6 per cent, sulfur 2 per cent, and calamine powders, and is applied once or twice a day. It was used by Drs. Saul Blau and Norman B. Kanof on 420 patients with good results in 339. The product is a surfactant that drys and produces mild desquamation.

Medical Letter consultants recently agreed that imipramine (Tofranil) was the drug of choice in the treatment of severe mental depression. In addition, they agreed that the hydrazine derivatives which inhibit (MAO) have also been used successfully in many cases.

They agree with most investigators that the drugs frequently relieve the more severe depression syndromes and reduce the need for electroconvulsive therapy.

Pfizer has been promoting Vistaril as an ideal drug for premedication in patients undergoing oral surgery. They report that it does not produce sedation or euphoria and that side reactions are few.

Entoquel is White Laboratories' new nonnarcotic drug for the symptomatic treatment of diarrhea in children. It is a palatable syrup that comes in two forms; one with thihexinol methylbromide for treating nonspecific diarrhea and the other with Neomycin for treating bacterial diarrheas.

Anti-Cancer Agent

Lilly's new anti-cancer agent made headlines recently in many papers throughout the country. The drug is available to the medical profession for treatment of generalized Hodgkin's disease and choriocarcinoma. Its name is Velban.

The clinical studies of Hodgkin's disease demonstrated that the drug produced significant reduction in the size of the involved glands in 31 of 34 patients. Twenty-three of these patients have been on maintenance doses of Velban and have maintained their improvement without relapse.

A spokesman for Eli Lilly makes it clear that Velban has not cured Hodgkin's disease or any other form of human cancer.

Information Center

The U. S. Vitamin & Pharmaceutical Corporation has opened in their New York offices, an emergency information center to answer inquiries from hospitals, emergency clinics, and physicians on the use of their new drug, Emivan. This product competes with other stimulants to combat overdosage of barbiturates, narcotics, and other chemicals.

Anything can happen in New York, but to send out a news release to introduce a telephone service is a roundabout way to tell the medical profession how to obtain information on a new drug. The logical assumption is that they want publicity relative to this product. On the other hand, they may hesitate to put their claims in writing. This may be a new trend for those wishing to avoid the pointing finger of the FDA.

Procaine Injections

Dr. C. C. Chiu treated 10 elderly patients with a series of procaine injections for up to 15 months. All had degenerative disease, and only

two showed improvement. According to his report in the J.A.M.A., a careful retrospective analysis showed that procaine was not responsible for the improvement.

The study was done in an attempt to confirm the work of Prof. Anna Aslan. She claims marked rejuvenating powers following injections of procaine in more than 20,000 patients. Her reports are only of a testimonial nature with sensational improvement in a wide variety of conditions, including senility, loss of memory, impotence, white hair, eczema, hair loss, arthritis, peptic ulcer, etc., etc., etc.

Science Writers' Dilemma

The press was invited recently to attend a conference "to explain a new way of life for women" at the New York Academy of Sciences. Dr. Rebecca Liswood discussed the product that may eliminate absorbents throughout the menstrual period.

This is a rather delicate subject for science writers and we would be interested in knowing how many papers told the story of the product — Tassette.

Enriched White Bread is Tops

Harris, Siemers, and Lopez[1] analyzed the nutrient content of typical breads collected from fourteen countries. The owners of many Health Food Shops will be surprised to learn that our enriched white bread ranked second in over-all nutritional value. A semi-white milk bread from Finland was first, and two semi-white breads from Switzerland were third and fourth respectively.

By type of bread, the enriched white breads which complied with United States enrichment standards ranked higher in over-all nutritional value than rye breads, semi-white breads, mixed wheat-rye breads, and lastly unenriched white breads. According to the authors, our enrichment formula now gives Americans a stable food that compares favorably with the breads of the world.

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[1]*Harris, Robert S., Siemers, Gustav, and Lopez, Hady: Nutrients in Breads from Fourteen Countries. J. Am. Dietet. A. 38*:27 (*Jan.*) 1961.

Birth Injury Shown In Teeth

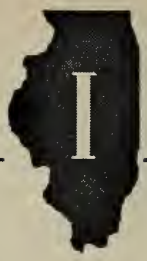
Dr. Maury Massler, head of the department of pedodontics at the University of Illinois College of Dentistry, made an interesting discovery. He studied the growth rings in children's teeth, noting the quality of the before-birth enamel and the nature of the enamel after birth.

Malformations were noted that suggest that the brain injury in children suffering from spastic disorders occurred at the time of birth. On the other hand, the findings suggested that the brain was damaged at about the fifth month of pregnancy in athetoid children with kernicterus. The project also suggested that mongolism may have a metabolic basis beginning at the seventh month in pregnancy.

Dental surgery in diabetics

When extensive dental procedures are planned [in a diabetic] close liaison between the physician and the dentist should be maintained. If dental surgery is planned on the ambulatory patient, it is best done during the descending portion of the blood sugar curve. Local anesthetic is the drug of choice, although a carefully controled general anesthetic administered by an anesthetist accustomed to diabetics is acceptable. Preoperative medication should be kept at a minimum. It is important that the presurgical and postsurgical patient maintains a satisfactory diet. Following multiple extractions, this can become a problem. Oral surgery performed in the hospital allows for superior control of diet and insulin dosage. If insulin has been used regularly by the patient, then at the time of operations, maintain the same total number of units in 24 hours; but divide into smaller and more frequent doses, irrespective of meals. *Sherwood H. Wolfson. D.D.S. The Diabetic and Dental Care. Delaware M. J. March 1961.*

ANNOUNCEMENTS



Illinois cancer crusade a winner

The 1960 Illinois Cancer Crusade, under the chairmanship of Harry J. Hemingway, president of the Sessions Engineering Company, surpassed all previous records and netted $19,804 over the 1959 total. The Illinois Crusade's total of $1,749,634 fell only $366 short of its goal, with total expense amounting to 8.79 per cent—well below standard expense percentages.

The Illinois Division took first place in the million dollar and over divisions in the percentage amount raised compared with the previous year's total. In dollars raised among all the divisions in the nation it went from third to second place.

Chest physicians annual meeting

The annual meeting of the American College of Chest Physicians will be held at the Commodore Hotel, New York, June 22 through June 26. Scientific sessions will be held June 24 through June 26.

A joint session with the Section on Diseases of the Chest of the American Medical Association will be held at the Coliseum June 26. This will be the first joint meeting in the history of the two societies. Fireside Conferences, also jointly sponsored, will be held at the Commodore Hotel the evening of June 26.

Thirty-nine Chicago physicians, two from Hines, and one from Hinsdale will participate in the program.

NU alumni luncheon

A luncheon for Northwestern University alumni, in conjunction with the American Medical Association Convention in New York June 25-30, will be held on Tuesday, June 27, at the Park-Sheraton Hotel, at 12:30 p.m. Dean Richard H. Young (Med. '30) will be present to speak to the group.

Tickets are $5 each and may be obtained in advance from the Medical Alumni Office, 303 E. Chicago Ave., Chicago 11, or in the registration area of the convention.

Teaching seminar

The fourth annual Summer Seminar in Medical Teaching, sponsored by the Association of American Medical Colleges, will be held June 11-17 at the Hotel Moraine in Highland Park. Medical teachers will join with specially qualified educationists of earlier conferences in an examination of teaching and learning in medical schools. Presentations, demonstrations, and discussions will include the nature of learning; the nature of medical students and faculties; the use of the familiar lecture and laboratory, ward exercise, and clinical conference as well as methods of instruction; tests and other appraisal devices for measuring student performance.

Attendance will be limited. For further information write Dr. Ward Darley, Executive Director of the AAMC, 2530 Ridge Ave., Evanston.

GP's tuberculosis symposium

The annual Symposium for General Practitioners on Tuberculosis and Other Pulmonary Diseases sponsored by the American Thoracic Society, the Saranac Lake Medical Society, and the Adirondack Counties Chapter of the New York State Academy of General Practice is scheduled for July 10-14 at Saranac Lake, N.Y.

A number of papers will be presented, and many of the sessions will be informal panel discussions with questions from the floor.

The symposium is acceptable for 27 hours of Category I credit by the American Academy of General Practice.

The registration fee is $60, and a deposit of $10, applicable to the total fee, is necessary for application. It is not refundable but may be applied toward a future symposium registration.

Family activities such as a scenic boat trip on Saranac Lakes and a bus trip to a Lake Placid fur and game farm may be arranged.

For further information write Mrs. Roma Commo, Registrar, Symposium for General Practitioners on Tuberculosis and Other Pulmonary Diseases, Box 627, Saranac Lake, N. Y.

"Conscience in Modern Medicine"

"Great Issues of Conscience in Modern Medicine," from the academic convocation at Dartmouth Medical School last fall, will be presented in a television series over National Educational Television Network stations in our area during June and July. Consult local listings or the stations for specific times.

The three programs are as follows:

THE ISSUES OF MAN AND HIS ENVIRONMENT
Warren Weaver, George B. Kistiakowsky, Walsh McDermott, S. Marsh Tenney, Ward Darley.

THE ISSUES CONCERNING MAN'S BIOLOGICAL FUTURE
Sir George Pickering, Brock Chisholm, Herman J. Muller, Rene J. Dubos, The Hon. Mahomedali C. Chagla, Aldous Huxley

THE ISSUES INVOLVED IN INFLUENCING THE MIND
Ralph W. Gerard, Wilder Penfield, Sandor Rado, S. Charles Snow

During the weeks of June 11-17 (number 1), June 18-24 (number 2), June 25-July 1 (number 3) on stations WTTW, Chicago; KETC, St. Louis; WMVS, Milwaukee.

During the weeks July 9-15 (number 1), July 16-22 (number 2), July 23-29, (number 3), on station WILL, Urbana.

TB societies joint meeting

The joint annual meeting of the National Tuberculosis Association and the American Thoracic Society will be held in Cincinnati May 21-25 in the Netherland Hilton Hotel.

In the general sessions on Wednesday a preliminary report of the U.S. prophylaxis trials will be given, and Thursday worldwide elimination of tuberculosis will be discussed.

Extensive programs of the medical sessions Monday through Wednesday include seminars, round tables, and symposia. There will also be public health, nursing, and business sessions. A number of Chicago physicians will be participating.

History of Medicine annual meeting

The American Association for the History of Medicine will hold its annual meeting May 18-20 in Chicago with general sessions at the Shoreland Hotel. Among the 18 papers being presented is one on "Liebniz and the Medical Faculty of Halle: Friedrich Hoffman and Georg Ernst Stahl" by Johannes Steudel of Bonn, Germany. Dr. Frederick Stenn, Chicago, will speak on "Ophiuchus, the Heavenly Constellation Named after a Physician."

Friday morning's program, a symposium on "Medical Lore and Practice in the Ancient Near East," will be held at the Oriental Institute, University of Chicago.

The Garrison Lecture, the dinner address, will be presented by George Rosen, New York, whose subject will be "The Dance Frenzy, Demonic Possession and Similar Psychic Epidemics" Thursday evening at 8:30 at the Quadrangle Club, University of Chicago. Dr. Morris Fishbein, Chicago, will deliver the banquet address on "Great Medical Editors" at the Shoreland Hotel Friday night.

Cytology award

The Maurice Goldblatt Cytology Award to stimulate basic research in cancer detection has been established by the Cancer Research Foundation. An award of $1,500 will be given for an outstanding contribution in the field of exfoliative cytology, which has become increasingly important in diagnosing cancer.

The award will be administered by the International Academy of Gynecological Cytology, Inc., Buffalo, N.Y., or by the University of Chicago.

The award jury will consist of Dr. Morris Fishbein, chairman of the Board of the Cancer

Research Foundation; Mr. Goldblatt as honorary chairman of the foundation; a medical or scientific consultant to be nominated annually; and the members of the Editorial Board of Acta Cytologica.

Physical Therapists' annual conference

The annual conference of the American Physical Therapy Association will be held at the Palmer House, Chicago, July 2-7. The theme of the scientific program will be "Aftercare Programs," dealing specifically with the pediatric patient, the ambulatory adult, and the geriatric patient.

Revised live birth form

Within the next 30 days, a revised Certificate of Live Birth Form will be distributed by the Department of Public Health, State of Illinois. Of significance is the requirement that the attendant at birth, whether an M.D., D.O., midwife, or other person, sign this certificate and "specify his or her Illinois license number."

The new requirement of specifying an Illinois license number fills an existing need. In the past, illegible signatures, signatures of unauthorized persons, and forgeries have not been uncommon. It is anticipated that the stating of one's Illinois license number will eliminate the majority, if not all, of these problems.

ICS section meetings

The French Section of the International College of Surgeons will hold a meeting June 16-18 in Vittel, France, and the New England Region of the U.S. Section of the College will have a meeting July 1-4 in Chatham, Barnstable, and Cape Cod, Mass.

Loan plan for new doctors

The new physician, confronted with the staggering expenses of setting up his practice, now can secure special financial assistance from Continental Illinois National Bank and Trust Company of Chicago.

The bank has developed a professional man's financial program for both new physicians and those already established in five Chicago-area counties — Cook, Kane, Will, DuPage, and Lake (Ill.).

The bank will loan funds to a new doctor to help him pay initial expenses, such as office equipment, rent and utilities, receptionist or nurse, medical society fees, moving charges, and living expenses. Repayment of the loan is deferred for six months. In many cases, a new physician may borrow money to repay a loan that was needed to complete his education.

The bank places special emphasis on helping new physicians get started in a community because of the essential services they perform, and the fact that their beginning expenses usually exceed the costs needed to start in other professions.

Procedures for entering the financial program are simple. A member of the bank staff helps determine the amount of loan funds necessary. At the same time, the bank establishes a checking account for the physician's professional use so that he may borrow conveniently by transferring funds from his loan account to his checking account. He then pays his bills by writing regular checks.

All or any part of the loan funds may be borrowed any time within six months after the account is opened. Charges for interest and processing are made on the money withdrawn. But repayment begins six months from the date the loan account is set up.

Established physicians also may participate in the program. Loans in this category, tailor-made to fit individual needs, usually would be for acquiring new, major equipment.

The Council of the Illinois State Medical Society approved this plan in principle on Dec. 11, 1960.

Old age hospitalization insurance

Continental Casualty Company, Chicago, is extending its old age hospitalization protection to a national basis through its combination insurance package consisting of "65 Plus," a short-term hospital-surgical plan, and "5,000 Reserve" plan. The plans stem from Continental's experience in insuring more than 1,000,000 persons in the retirement years.

Continental's two-part combination package was designed on the basis of four principles

which the company believes are vital to the effectiveness of any old age health plan, namely: (1) the insurance must be available to everyone 65 and over; (2) it must be permanent; (3) it must cover medical and health conditions existing prior to enrollment; and (4) it must have a low monthly premium.

Under a new policy, persons not now 65 may apply for the program at any time within 30 days after reaching their 65th birthday. In effect, this means a continuing enrollment program for persons reaching the age of 65.

Persons now 65 and older could enter the program this year only during a 10-day enrollment period, April 8 to 18.

The basic plan, 65-Plus, pays up to $10 a day up to 31 days for hospital room and board, up to $100 for hospital services such as x-rays and laboratory tests, and also pays from $5 to $200 for surgical operations according to the policy schedule.

The second plan, 5,000-Reserve, is designed for long-term hospital confinements up to two years. It pays up to $5,000 for each hospital confinement after a deductible $500, covering hospital room and board expense up to $25 per day as part of the program. If the insured has the 65-Plus plan, most of this deductible amount can be paid out of that.

Premiums are $6.50 a month for 65-Plus; $7 a month for 5,000 Reserve, or $13.50 a month for the two plans combined.

Continental's plans pay benefits regardless of any additional hospitalization insurance, private or government, which the insured may have now or in the future.

Hypertension and kidney disease study

A nationwide program to attack high blood pressure caused by kidney disease was launched at Northwestern University Medical School at a special meeting of medical experts in April.

It is to include examination of records of thousands of patients in medical schools and hospitals throughout the United States and Canada, with nearly 50 physicians collecting data. The cooperative program is sponsored by the National Heart Institute. Data will be collected by the individual researchers, then recorded and processed by IBM cards to assess the facts.

Hypertension is caused by kidney disease in about one in four cases.

Change Colorado's annual meeting date

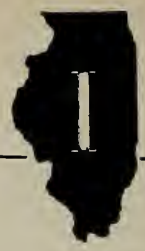
The annual session of the Colorado State Medical Society at the Shirley Savoy Hotel in Denver has been changed from September 19-21 to October 1-4.

The session was postponed to reduce the volume of meetings in Denver early next fall. The change in date will enable the society to overlap and merge its meeting with that of the Congress on Occupational Health October 3-4 at the Brown Palace Hotel.

Clinics for crippled children

June 1 - Effingham, St. Anthony Memorial Hospital
June 2 - Chicago Heights (Cardiac), St. James Hospital
June 7 - Alton (Rheumatic Fever), Alton Memorial Hospital
June 7 - Carmi, Carmi Township Hospital
June 7 - Hinsdale, Hinsdale Sanitarium
June 8 - Springfield, St. John's Hospital
June 9 - Evanston, St. Francis Hospital
June 13 - East St. Louis, St. Mary's Hospital
June 13 - Peoria, Children's Hospital
June 14 - Champaign-Urbana, McKinley Hospital
June 15 - Elmhurst (Cardiac), Memorial Hospital of DuPage County
June 15 - Rockford, St. Anthony's Hospital
June 20 - Belleville, St. Elizabeth's Hospital
June 21 - Chicago Heights (General), St. James Hospital
June 22 - Bloomington (A.M. - General), (P.M. - Cerebral Palsy), St. Joseph's Hospital
June 27 - Peoria, Children's Hospital
June 27 - Effingham (Rheumatic Fever), St. Anthony Memorial Hospital
June 28 - Elgin, Sherman Hospital
June 28 - Springfield (P.M. - Cerebral Palsy), Memorial Hospital

NEWS of the STATE



County

Adams

Fifty-three scholastically superior seniors from the seven Adams County high schools have been chosen award members of the Society for Academic Achievement. The students, with their school principals and councilors, will be the guests of the County Medical Society and its Swanberg Medical Foundation at the society's joint luncheon meeting with the Quincy Kiwanis Club on May 22.

The Kiwanis Club and the Medical Foundation are the principal sponsors of the SAA program internationally; the medical society and the medical foundation are its sponsors in Adams County.

The SAA has been declared federal income tax exempt by the Bureau of Internal Revenue. This means that all contributions, bequests, legacies, devises, transfers, or gifts made to the society are deductible by donors for federal estate and gift tax purposes.

Its status is that of an organization planned and operated exclusively for educational purposes. It promotes, popularizes, and rewards high academic achievement in American and Canadian high schools; it also early identifies superior and talented students, provides guidance services for them, and motivates them toward college.

Cook

Appointment. Dr. Wright Adams has been named associate dean of the biological sciences, dean of the clinical faculty, and chief of staff of the University of Chicago Clinics, a newly created executive post at the university. He has been a member of the medical faculty for 31 years.

Earlier this month, Dr. Adams was named chairman of the American Board of Internal Medicine.

Included in the Division of the Biological Sciences are 26 academic departments, institutes, and committees, and twelve hospitals and clinics. More than 17,000 bed patients and 175,000 outpatients are cared for annually. It has a full-time faculty of 288, 288 medical students, and 240 graduate students.

Dr. Adams, a professor of medicine and an authority on heart disease, has served since 1949 as chairman of the department of medicine, the largest of the division's academic departments.

Dr. Leon Jacobson will be acting chairman of the department of medicine until Dr. Adams' successor is named. Dr. Jacobson is director of The Argonne Cancer Research Hospital which the University of Chicago operates on campus for the U.S. Atomic Energy Commission.

Lecture. Dr. T. Holmes Sellors gave the seventh Walter Wile Hamburger Memorial Lecture at the Institute of Medicine of Chicago's recent joint meeting with the Chicago Heart Association. Dr. Holmes, surgeon to the National Heart, London Chest, and Middlesex hospitals, England, spoke on "Cardiology and the Surgeon."

Prizes and scholarships

Six house physicians in Chicago hospitals were among the prize winners in the $10,000 nationwide Mediquiz Contest sponsored by the medical journal, Resident Physician.

Drs. Kenneth Cohen and Gerhard H. Haase of Cook County Hospital each won $100 cash prizes, and four $25 prizes went to Drs. David E. Comings, Cook County Hospital; Arnold M. Tarar, Michael Reese Hospital; Paul D. Urnes, Pas-

savant Memorial Hospital; and Bronius Valadka, Veteran's Administration Hospital.

The five-month contest, intended to stimulate the reading of all current medical journals, consisted of 100 questions based on information in 48 current medical journals on file in hospital libraries. Contestants had to hold approved internships or residencies in a hospital.

Nearly 2,600 from 30 states entered the contest.

Drs. Hans von Leden and Paul Moore of Northwestern University received the first Bucranio Award at the annual meeting of the American Speech and Hearing Association for their investigative work on the physiology of the pathologic larynx.

Susan F. Anderson, Marysville, Ohio, and John E. Dunn, Elgin, are the co-winners of the Frederick H. Rawson, Jr. scholarship for the outstanding sophomore medical student at Northwestern University Medical School. The $750 awards were given for high standing as students and devotion to the field of medicine.

The scholarship aid is given by the family of Mr. Rawson, who died while a medical student at Northwestern.

TB Detection Project. The Back of the Yards Neighborhood Council of the Tuberculosis Institute of Chicago and Cook County is conducting a pilot project for the detection of every active and inactive case of TB in a six square-mile area of about 51,000 people in Chicago's South Side. Called the Back of theYards Project, the idea for it first came from Joseph Meegan, executive secretary of the council.

The project's Ad Hoc Advisory Committee, under the chairmanship of Dr. William Kellow, Institute board member, is composed of members from the following agencies: The Institute, The Council, The Municipal Tuberculosis Sanitarium, the Chicago Board of Health, the Chicago Board of Education, and the Catholic Archdiocese of Chicago.

The committee met last January to discuss ways and means of putting the plan into action and integrate its essentials. Preliminary plans include x-raying every person over 15 years of age in the Back of the Yards.

The actual x-raying and testing will be done at two different intervals beginning May 15 and continuing until June 9 and from July 7 through August 2. It is estimated that it will take six months to carry out the clinical follow-up of all TB suspects found in the testing. The project should be finished around the end of the year and holds the prospect of giving basic information not had previously.

The x-raying will be done by the Institute and the MTS. The latter will also do the film reading and use its facilities for the necessary follow-up work.

A professional and technical committee, comprised of qualified professional and technical personnel from the interested agencies, will determine the adult group to be tested and all other procedural matters.

Appointments and elections. Dr. Melvin Sabshin will become head of the department of psychiatry in the University of Illinois College of Medicine on September 1, succeeding Dr. Francis J. Gerty, who has been appointed State Director of Public Welfare.

Dr. Sabshin is now associate director of the Institute for Psychosomatic and Psychiatric Research and Training at Michael Reese Hospital and was recently named one of Chicago's ten outstanding young men of 1960 by the Junior Chamber of Commerce.

Alvin Dubin was named assistant professor of biological chemistry in the university's College of Medicine.

Dr. Roland P. Mackay, senior attending neurologist at Presbyterian-St. Luke's Hospital, has been made chairman of the hospital's newly created department of neurology. Dr. Mackay joined St. Luke's staff in 1930 and also is professor of neurology at the University of Illinois College of Medicine. He is a past president of the American Neurological Association.

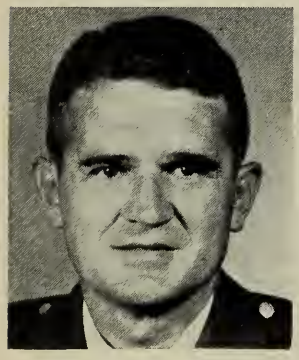
Dr. Edwin I. Hirsh was appointed director of the radiology department of the nearly completed Gottlieb Memorial Hospital. At present he is associate radiologist at Englewood Hospital and diagnostic radiological consultant to the Veterans Administration Hospital in Dwight.

Dr. Hardin E. Coen has been elected medical staff president of Louis A. Weiss Memorial Hospital, Chicago. Dr. Lawrence I. Bernard was

named vice president, and Dr. Harold R. Kamenear became secretary.

Among the new faculty appointees and staff promotions at the Chicago Medical School are: Drs. John C. Lee, named associate professor of psychiatry; Umberto Saffiotti, made assistant professor of oncology (cancer); Abraham Towbin, appointed professor of pathology, and Wei-Ping Loh, promoted from associate to assistant professor of pathology; M. Hans Elias, promoted from associate professor to professor of anatomy; and William Schumer, promoted from clinical instructor to full-time assistant professor of surgery.

Other physician appointees are: Harry J. Yellen, clinical associate professor of medicine, August P. Hovnanian, associate professor of surgery; and Donald MacCanon, assistant professor of physiology and pharmacology and chief of experimental cardiology.



Dr. T. A. Kiersch

Dr. Theodore A. Kiersch, chief of the department of neuropsychiatry, Letterman General Hospital, San Francisco, has been made head of the Mental Health Division, University of Illinois Health Service. He will assume office September 1 after retirement as colonel from the U.S. Army Medical Corps. As division head he will conduct psychiatric work and coordinate duties of four other staff members.

Dr. Kiersch was chief of the department of neuropsychiatry, U.S. Army General Hospital, Frankfurt, Germany, from 1954 to 1957, when he was assigned to his present position.

Dr. R. G. Noviek, medical director of Forest Hospital, has been invited to serve on the Professional Advisory Committee of the Illinois Association for Mental Health. He is a former medical director of the Illinois Society for Mental Health.

Dr. Noel G. Shaw, Evanston, was elected president of the Illinois Committee for Maternal and Infant Health. He is on the staff of St. Francis Hospital where he was chairman of the department of pediatrics from 1953 to 1958, and is assistant attending pediatrician at Presbyterian-St. Luke's.

He is a past president of the Chicago Pediatric Society and past chairman of the Section of Pediatrics of the Illinois State Medical Society.

Forest Hospital, Des Plaines, has added two psychiatrists to its staff: Dr. H. Roy Johnson and Dr. David Roth, both of Chicago.

The following Illinois physicians were elected fellows of the American College of Radiology at its annual meeting: Homer W. Vanlandingham, Rockford; Geza G. Kopstein, Evanston; and Marion F. Maglotti, Riverside. Fellowships are given for outstanding achievements and contributions to the art and science of medicine in general and radiology in particular.

Northwestern awards. The Northwestern University Medical School presented three faculty members with citations for outstanding achievements to medicine recently. Recipients were Dr. Samuel M. Feinberg, professor of medicine; Dr. Lowell D. Snorf, professor emeritus of medicine; and Dr. Don C. Sutton, professor emeritus of medicine.

Forest Hospital Given 3-year Approval. Full 3-year approval has been given to Forest Hospital, Des Plaines, by the Joint Commission on Accreditation of Hospitals, made up of representatives from the American Hospital Association, The AMA, American College of Surgeons, and the American College of Physicians.

One-year approval, the first step in accreditation, was given Forest Hospital last year after an initial visit. The full 3-year approval was granted after inspectors made a second visit and reported their findings to the commission.

Honored. Dr. Loyal Davis, professor and chairman of the department of surgery at Northwestern University Medical School, has received an honorary degree of Doctor of Science from Temple University.

Dr. Davis is an honorary fellow of the Royal College of Surgeons of Edinburgh and of the Royal College of Surgeons of England. He also

is chairman of the board of regents of the American College of Surgeons and a past president of the American Surgical Association.

Medical Publications for Korea. The Presbyterian Medical Center has recently shipped over a thousand medical journals and textbooks to the Yonsei Medical School in Seoul, Korea. This is part of its library's program of helping foster medical education in various parts of the world.

The plan was originally begun by Dr. John J. Niebauer, former chairman of the Medical Center's Library Committee, and Dr. Theodore D. Stevenson, medical secretary of the Commission on Ecumenical Mission and Relations of the United Presbyterian Church.

Anyone who would like to donate back copies of medical journals, textbooks, and the like should contact Mrs. Maria Martinez, the Medical Center's librarian, at Clay and Webster Sts., or send the volumes directly to the Medical Center Library.

Grants

Dr. Arthur Veis, Skokie, associate professor of biochemistry at Northwestern University Medical School, has been awarded a five-year Senior Fellowship grant of $63,000 by the U.S. Public Health Service. The grant is for the continuation of a long-term research program aimed at learning the fundamental chemical and physical changes involved in the aging of connective tissues of the body.

The Armour Research Foundation, Chicago, is one of 33 investigators given medical and social research grants totaling $274,039 by the National Tuberculosis Association for the fiscal year beginning April 1. Its research project is the study of modification of the tuberculin test.

The grants will aid research projects in 18 states, the District of Columbia, Canada, Holland, and Japan. The NTA's research program is supported by Christmas Seal funds.

A grant of $22,000 was given the outpatient psychiatric clinic of Presbyterian-St. Luke's Hospital by the Illinois Welfare Department. It will permit an expansion of the clinic, presently only for adults, to include similar services for children and will assist in providing increased training and research facilities in child psychiatry.

With the addition of Presbyterian-St. Luke's Hospital, 11 of the 29 state-aided community mental health clinics now receiving these special allocations are in the Chicago area. More than 12,000 patients were seen last year by them, approximately 1,000 being patients on conditional discharge from the state mental hospitals.

Governor Kerner recently released $8,630.15 to the Illinois Department of Public Welfare for improvements at the following state institutions: Alton State Hospital $1,987.20; Peoria State Hospital $1,842.95, and Illinois Eye and Ear Infirmary, Chicago, $4,800.

The University of Illinois College of Medicine has received a $16,000 grant from the Avalon Foundation to be used for medical scholarships. Grants for student scholarships totaling approximately $1,100,000 were awarded to each of the 86 medical schools in the United States.

This is the first grant across the board for medical student scholarships by any foundation. The amount available to each four-year medical school varies from a minimum of $10,000 to a maximum of $16,000, based on the size of the student body and scholarship funds currently at the disposal of each school.

The University of Illinois College of Medicine, with the second largest student enrollment in the United States, received the maximum grant.

The grants are an unrestricted supplement to the scholarship funds of each medical school, to be expended in conformity with the school's policy and to be available until expended for nonrefundable grants to students.

Two Illinois students were among thirty junior and senior medical students from across the nation named as 1961 winners of foreign fellowships from a $180,000 grant by Smith Kline & French Laboratories.

They are Derald E. Brackman, junior, University of Illinois College of Medicine, from Buckley, Ill. — a $1,567.56 grant for ten weeks at the Likwenu Hospital, Likwenu, Nyasaland, Africa; and Donald M. Megill, junior, University of Chicago School of Medicine, from Vassar, Kan. — a $1,294.70 grant for five months at

Evangelical United Brethren Hospital, Rotifunk, Sierra Leone, West Africa.

Fellows are chosen by a Selection Committee of the Association of American Medical Colleges. The amount of each award is determined by individual expense and need.

The recipients will travel to Pakistan, Korea, Japan, Burma, Haiti, New Hebrides, India, Thailand, Cambodia, Ghana, Republic of Congo, Tanganyika, and other African countries, to work in mission hospitals and outpost medical facilities. They must spend at least 10 to 12 weeks at these locations gaining firsthand experience of varying cultures and peoples while introducing modern U. S. medical procedures.

The Commonwealth Fund of New York City has awarded $128,000 to the University of Illinois College of Medicine for a two-year study and evaluation of its over-all program in medical education. This is a renewal of an original endowment of $112,000 for a two-year period ending Sept. 1, 1961.

The grant provides for a full-time staff enabling the administration and faculty to carry out an intensive study of scientific teaching methods, advance instruction in patient care, and development of a permanent program of educational research. Included will be the assessment of the patterns of and needs for participation in patient care programs of health professions personnel other than physicians.

Efforts also will be made to determine how the College of Medicine can best utilize the resources of other departments in the university as well as other institutions in the West Side Medical Center District.

Heart Seminar. Dr. Angelo P. Creticos, clinical assistant professor of medicine, University of Illinois Hospitals, spoke at the Chicago Heart Association's Seminar for Social Workers April 28. His subject was "Current Concepts in Management of Patients with Cardiovascular Diseases" at the seminar whose theme was "Medical-Social Factors in the Rehabilitation of Patients with Cardiovascular Diseases."

Kankakee

Dr. Roy A. Hecht, associate medical director of the Armour Pharmaceutical Company, Kankakee, has been made a fellow of the American Academy of Allergy. Elected to the Academy in 1958, he was honored for his research on allergies. Currently he is working on the role of proteolytic enzymes in allergic diseases.

Knox

Dr. Seymour L. Pollack, associate professor of neurology at Louisiana State University Medical School, New Orleans, has been appointed assistant superintendent of the Galesburg State Research Hospital. Dr. Pollack is a diplomate of the American Board of Psychiatry and Neurology and a member of the American Psychiatric Association.

Lee

Medical Society meeting. Joseph Neal, legal counsel for the Illinois State Medical Society and Registrar of the Cook County Hospital Graduate School of Medicine, was the speaker at a recent meeting of the Lee County Medical Society. His subject was "Socialized Medicine; its Pros and Cons, versus 'British Socialized Medicine.'" The following officers were also elected at the meeting: Dr. Wayne Spenader, Sublette, president; Dr. Howard Edwards, Jr., vice president; Dr. Samuel Adler, secretary-treasurer; Dr. William McNichols, Jr., delegate; and Dr. Charles LeSage, alternate delegate, all from Dixon.

Madison

At a recent meeting of the Madison County Medical Society Dr. Gordon Moore commented on the need for laboratory technicians and dieticians in that area. He felt that Southern Illinois University might investigate education and training in these subjects.

Dr. Moore moved that the president of the Society appoint a standing committee to (1) meet with Dr. Delyte Morris, president of Southern Illinois University, and make known to him the great need for medical technicians and dieticians in Southern Illinois, (2) encourage SIU to incorporate studies in medical technology and dietetics, and (3) offer the services of the physicians in formulating the above policy.

The motion was seconded by Dr. Young and passed.

McDonough

"Experiences with the National Health in England" was the subject of the March 24 meeting of the McDonough County Medical Society.

Morgan

Dr. Donald L. Unger, clinical assistant in medicine (allergy), Stritch School of Medicine of Loyola University, addressed the Morgan County Medical Society March 7 on "Recent Advances in Allergy."

Arrangements were made by the Committee on Postgraduate Medical Education and Scientific Service.

Stephenson

Dr. Vincent Freda, professor at the Illinois Research Hospital, addressed the Stephenson County Medical Society on "Carcinoma In Situ of the Cervix" at a meeting on April 20.

The program was arranged by the Postgraduate Medical Education and Scientific Service Committee of the Illinois State Medical Society.

Washington

Election. The following officers were elected at a recent meeting of the Washington County Medical Society: Dr. Walter P. Plassman, Ashley, president; Dr. Roscoe C. Vernor, Nashville, vice president; and Dr. William P. Lesko, Nashville, secretary.

General

Public welfare appointees

Lowell E. Sachnoff has been made special executive assistant to Dr. Francis J. Gerty, director of the Illinois Department of Public Welfare. Mr. Sachnoff will act as legal counsel for the department and be responsible for developing the legislative programs necessary for organization and creation of a new code Department of Mental Health. He will work with Lieut. Gov. Samuel H. Shapiro.

Mr. Sachnoff is a Phi Beta Kappa graduate of Harvard College and Law School and has been associated with the Chicago law firm of Ross, McGowan and O'Keefe. He has been a member of Dr. Gerty's Citizens Advisory Committee.

Dr. Paul E. Nielson, Chicago, has been appointed a member of the Psychiatric Training and Research Authority in the Public Welfare Department. His term will expire in January, 1965. At present he is acting head of the department of psychiatry at Presbyterian-St. Luke's.

Dr. Newell named to Neuro-ophthalmology Commission

Dr. Frank W. Newell, professor and chairman of ophthalmology, University of Chicago, has been named a founding member from the United States on the world-wide Problem Commission in Neuro-ophthalmology. The appointment was made by the World Federation of Neurology from its headquarters in Antwerp, Belgium.

Dr. Newell went to the first meeting of the new commission March 18-19 in Geneva, Switzerland. Representatives from France, Italy, Belgium, Switzerland, and Japan also attended the meeting.

The commission will encourage research in areas where the population is most seriously affected by blindness, such as Asia and South and Central America.

Directs PR

The Visiting Nurse Association of Chicago has selected Mrs. Marda Alexander, Evanston, as director of public relations. She has served as director of information for the National Merit Scholarship Corporation, public relations counsel for the Civil War Book Club, and the Abraham Lincoln Book Shop, and as publicity chairman for the Wieboldt Foundation's Community Project for the Aged.

Dr. Grossman heads Pediatric Institute

Dr. Herbert J. Grossman, Los Angeles, has been named superintendent of the Illinois State Pediatric Institute, effective July 1. Dr. Gross-

man served in the Army Medical Corps 1947-1949 as chief of the contagious disease section in the 97th General Hospital, Frankfurt, Germany, and as a member of the research team at the Army Hepatitis Research Center, Bayreuth, Germany.

From 1951 to 1958 he held positions in various hospitals as researcher, attending pediatrician, consultant in pediatrics, medical consultant at a guidance center for handicapped youth, lecturer, and attending physician in pediatrics.

Deaths

George D. Allen*, Naperville, a graduate of the Chicago College of Medicine and Surgery in 1917, died March 6, aged 70. Semi-retired since 1945, he had been on the staff of Oak Park Hospital more than 25 years and had practiced in Berwyn many years.

S. Howard Armstrong, Jr.*, Chicago, a graduate of the Harvard Medical School, Boston, in 1937, died March 11, aged 48. He was dean of the Cook County Graduate School of Medicine and professor of medicine at the University of Illinois School of Medicine. In 1953 he joined the staff of Cook County Hospital and at the time of his death was director of biological sciences and medical education there. He came to Chicago from Boston in 1948 to take the post of chairman of the department of medicine at Presbyterian Hospital, now Presbyterian-St. Luke's, and remained there until 1952. He also had been an attending physician at the University of Illinois Hospital.

Dr. Armstrong taught at Peter Bent Brigham Hospital, Boston; Boston City Hospital; Massachusetts Institute of Technology; and Harvard Medical School before coming to Chicago. He had served on the editorial board of the Journal of the American Medical Association and as a consultant to the United States Public Health Service, and was scientific director of the Hektoen Institute.

He was active in education in protein metabolism and kidney disease and participated in basic studies at the start of World War II in the use of plasma on the battle field.

He was a member of the Chicago Yacht Club, the Eastern Yacht Club of Marblehead, Mass., and the yacht squadron of the Tennis and Racquet Club, Boston.

Phebe Block* (see Pearsall-Block).

Emmet P. Carroll, Chicago, a graduate of the Chicago College of Medicine and Surgery in 1916, died March 19, aged 78. He was a staff physician at St. Joseph's Hospital and a fellow of the American College of Surgeons.

Edwin F. Condon*, Rock Island, a graduate of the Creighton University School of Medicine, Omaha, in 1925, died March 10, aged 62. He had practiced in Rock Island since 1924 and together with Mrs. Condon had owned and operated the Comfort Harbor Convalescent and Nursing Home in Milan, Ill., since they founded it in 1946.

John A. Kerst*, Springfield, a graduate of the Northwestern University Medical School in 1929, died March 10, aged 65. He was on the staffs at Memorial and St. John's hospitals in Springfield, and St. Vincent's Hospital in Taylorville. He did postgraduate work at Harvard University, George Washington University, and in New York. He had been a resident physician at the Massachusetts Eye and Ear Infirmary in Boston and an instructor at Northwestern University Medical School from 1939 to 1955.

He had memberships in the American College of Allergists, Chicago Ophthalmological Society, and the Central Illinois Society of Ophthalmology and Otolaryngology. He also belonged to the Masons, Consistory, and Ansar Shrine, and was a veteran of World Wars I and II, serving as a medical corps major in the second World War.

Abraham M. Lazar*, retired, Miami Beach, a graduate of the Stritch School of Medicine of Loyola University, then the Loyola University School of Medicine, in 1923, died March 4, aged 63. He had lived in Miami Beach since he retired five years ago. He had been an attendant in the otolaryngology department at Mount Sinai Hospital and an associate professor at the Chicago Medical School and was an Army major in World War II.

Roy R. Loomis*, Warsaw, a graduate of the Keokuk Medical College of Physicians and Surgeons in 1900, died July 28, aged 87. He was a member of the 50-Year Club of the Illinois State Medical Society.

Abraham M. Oberman*, Chicago, a graduate of the Northwestern University Medical School in 1909, died March 10, aged 77. He was a health officer for the Chicago health department from 1911 to 1947.

He was a member of the McDonough County Medical Society, the Mohammed Shrine at Peoria, Consistory at Quincy, and the P. J. Pickett Masonic, Odd Fellow, and Elks lodges.

Phebe Pearsall-Block*, Moline, a graduate of the University of Minnesota College of Medicine in 1913, died March 8, aged 79. She had practiced in Moline since 1915 and was a past president, secretary, and treasurer of the Rock Island County Medical Society. She was a member of Alpha Epsilon Iota medical society.

Irwin A. Port*, Chicago, a graduate of the University of Illinois College of Medicine in 1907, died February 28, aged 77. He had been on the staff at Jackson Park Hospital for many years.

Bert Roan*, Bushnell, a graduate of Bennett Medical College in 1914, died March 1, aged 70. He had practiced in Bushnell from 1918 until his death, served two terms as mayor of the town, and was on its school board many years. He also was the Burlington railroad physician and surgeon there.

Karl G. Rundstrom*, retired, Oak Park, a graduate of the Chicago Medical School in 1933, died December 1959, aged 56.

Edwin Warner Ryerson*, Chicago, a graduate of the Harvard Medical School, Boston, in 1897, died March 6, aged 88. He came to Chicago in 1899 after studying in Berlin and Vienna and serving as house surgeon in Children's Memorial Hospital, Boston. He was emeritus orthopedic surgeon at St. Luke's Hospital, a professor of orthopedic surgery at Northwestern University Medical School from 1927-1935; president of the American Orthopedic Association in 1925 and the American Academy of Orthopedic Surgeons in 1933; and vice president of the American Board of Orthopedic Surgery from 1935-1938. In World War I he was a major in the Army Medical Corps.

Elmer E. Simpson*, retired, Oxford, Maryland, a graduate of the Northwestern University Medical School in 1894, died March 12, aged 94. He was one of the original staff members of Englewood Hospital in Chicago, remaining there until his retirement 20 years ago, and had practiced in Chicago for 51 years.

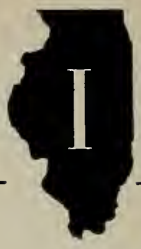
Samuel J. Sullivan*, Chicago, a graduate of the University of Illinois College of Medicine in 1927, died March 14, aged 62. He was a staff surgeon at Jackson Park Hospital and president of the South Chicago Branch of the Chicago Medical Society in 1940. He served in World Wars I and II and was a commander in the naval reserve. He was a member of the Chicago Urological Society and the Society of Abdominal Surgery.

John B. Werren*, Dixon, a graduate of the Bennett Medical College in 1900, died March 2, aged 90. He was a Dixon physician for over 30 years and practiced in the Dixon area for over 60 years. He was a member of the Lee County Medical Society, the Royal Arch Masons, and the Elks.

Lawrence C. H. E. Zeigler, retired, Chicago, licensed to practice in 1899, died March 18, aged 92.

**Indicates member of Illinois State Medical Society*

BOOK REVIEWS



OBSTETRICS. J. P. Greenhill, M.D. $17. Pp. 1052. Philadelphia, W. B. Saunders Company, 1960.

In 1913 Joseph Bolivar De Lee published the First Edition of "Principles and Practice of Obstetrics" and re-edited the volume six times during the succeeding 25 years. Greenhill edited the Eighth Edition of De Lee and has continued as editor through the present volume; but, inasmuch as the name De Lee has been deleted, perhaps the publisher should more rightly consider this the First Edition of Greenhill rather than the twelfth as he does. "Gray's Anatomy" is now in its hundredth year of publication, having had a succession of eleven editors all of whom respectfully retained the name Gray. It seems to me that the name De Lee could also have been perpetuated and with no loss of prestige to the present editor.

This present work is a compilation of 23 contributors, 21 of whom are American; one is English, and one is Filipino. Only eight are obstetricians, the remaining 15 being representative of other branches of medicine. It has been aptly divided into two parts, one devoted to the physiologic and the other to the pathologic aspects of reproduction in all its phases. The usually included chapter on anatomy has been deleted. Such a section in an obstetrical text always did seem rather superfluous.

The *Anatomy and Physiology of the Lower Uterine Segment* are excellently described. *Postmaturity,* that enigma of most obstetricians is sensibly discussed. *Nutrition, Endocrinology,* and the *Rh Problem* are all presented very succinctly and are quite up-to-date. McCartney's chapter on *Toxemia* is painstakingly thorough and very informative as is the section on *X-ray* with its special attention to the real and supposed dangers of exposure. The editor rightfully questions the need for repetition of courses of *Antisyphilitic Therapy* with each succeeding pregnancy in spite of the absence of evidence of infection. Since publication, the use of parenteral iron has been found to be not without significant complications; *Analgesia* is presented at great length, but one must question its value, inasmuch as a textbook is so long in the making and so soon outdated and trends in drugs change almost daily. A large number of physicians must certainly disagree with the editor's statement that scopolamine has no effect on the fetus. The chapter on *Hydatidiform Mole and Chorion Epithelioma* is naturally well done having been written as it was by Acosta-Sison, one of the world's foremost authorities on the subject. There is a fine chapter on *Pathological Affections of the Newborn.*

The editor frequently quotes alleged authorities but makes no editorial comment as to their accuracy and reliability. The arrangement of topics is not too conducive to use as a medical school textbook, but the work has unquestioned reference value. In referring to periods of gestation it would be preferable to use weeks (7 days) rather than months (28-31 days) as is the custom now in most modern maternities. One cannot help wondering how the author convinced himself that hiccup and thumb sucking actually occur in utero!

John P. FitzGibbons, M.D.

COMMUNITY RESOURCES IN MENTAL HEALTH. Reginald Robinson, Ph.D., David F. De Marche, Ph.D., and Mildred K. Wagel, M.S.S.A. $8.50. Pp. 436. New York, Basic Books, Inc., 1960.

This volume is the fifth of a series of monographs to be published by the Joint Commission on Mental Illness and Health. Five other documents are to be published as part of a national

mental health survey following which a final report will be prepared containing findings and recommendations for a national mental health program.

Dr. Robinson and his associates were charged by the Joint Commmission "to gain knowledge and understanding of community resources in support of mental health so that their contribution to the nation's mental health may be facilitated and increased." The investigators were also to see what resources were available at their command and if these were being utilized. Assets and debits in the various mental health programs were to be observed, measured, and if the picture was not too comforting, constructive help was offered for the future.

Doctors Robinson and De Marche together with Miss Wagle undertook a quantitative study of the supply of certain community resources in each of the 3,103 counties in continental United States. Their findings were disturbing enough, for in the rural areas virtually no resources exist. In contrast were the well developed and smoothly operating resources in the big cities. Fewer than 10 per cent contained family case work agencies, either private or public. Over all was found a tragic shortage of adequately trained personnel, and this in every area the authors investigated.

The chapter headings such as Public Health Service, Public Health Insurance, Pubilc Health Assistance, Child Welfare, Court Services, The Schools, Recreation and Group Work, The Churches, The Family Casework, Mental Health Clinics, etc., certainly give the reader every assurance that the authors made no spot checkings but instead made carefully controlled over-all studies. They are carefully written and contain hard hitting inescapable facts that the country is lagging badly in terms of mental health resources almost everywhere.

The authors make four broad and daring recommendations to the Joint Commission on Mental Illness and Health.

1. It is imperative that community mental health programs be shaped around local needs.

2. Professional help is required to develop mental health resources.

3. Manpower is essential for the various agencies, and jobs and opportunities must be made attractive. Salaries should compete successfully with those in other professions.

4. A broad research program must be undertaken—and soon.

This volume is a daring report which is directed to the professional and nonprofessional reader at the same time. It can create a desire to take action on a grand scale. The will is there but what of the way? We must necessarily wait until all ten reports are in before specific recommendations which, with implementation, may finally direct this national problem of such appalling magnitude into the right avenues for correction.

Louis D. Boshes, M.D.

On the History of Medicine, Henry E. Sigerist, M.D., edited by Felix Marti-Ibanez, M.D. $6.75. Pp. 313. New York, MD Publications, 1960.

and

On the Sociology of Medicine, Henry E. Sigerist, M.D., edited by Milton I. Roemer, M.D. $6.75. Pp. 397. New York, MD Publications, 1960.

These two companion volumes have attempted to capture the "best of Sigerist". In the volume, "On the History of Medicine," the essays selected include such scholarly items as "A Boerhaave Pilgrimage in Holland," "The Foundation of Human Anatomy in the Renaissance," "Paracelsus in the Light of Four Hundred Years;" equally scholarly, but perhaps more imaginative discourses such as "Ambroise Paré's Onion Treatment of Burns," to the more whimsical and humorous essays entitled, "American Truffles: A Thanksgiving Fantasia" and "The Spelling of Proper Names, or the Importance of Being Ernest." This reviewer found the final essay, "The Physician's Writing and Reading," particularly interesting as a highly personalized discussion of the problem in general and a revelation of Sigerist's spirit and philosophy. The numerous other essays which make this delightful reading were largely selected by Sigerist himself before his death.

Fitting to this anthology are the perceptive foreward by Dr. John F. Fulton, and the almost reverent introduction by Dr. Felix Marti-Ibanez. This reviewer can enthusiastically recommend the book to those interested in the whimsical and scholarly touch and excellent prose of one of the great authorities of medical history.

"On the Sociology of Medicine" is a series of essays devoted to the relationship of medicine as a whole to the problems of society — considered economically and sociologically. It is clear that, to Sigerist, medicine seemed to be a social science. The essay "The Place of the Physician in Modern Society" considers the primary aim of medicine to be "to keep individuals adjusted to their environment as useful members of society." Akin to current discussions among medical educators is the observation that "the physician uses methods of the natural sciences every day but for a social goal." Each essay is written in the excellent, conversational style of the late Dr. Sigerist permitting the impression that the reader is participating in a thoughtful discussion in the living room of the author.

Many readers will disagree with the arguments of Dr. Sigerist, who was obviously a proponent of the socialization of medicine, but most would agree that he states his arguments well. Some of the essays written in the thirties seem almost irrelevant today. Others which view the history of medicine in terms of the development of man are as timeless as is all history.

Hyman J. Zimmerman, M.D.

Clinical Cardiopulmonary Physiology. Burgess L. Gordon, M.D. $28.50. Pp. 1001. New York, Grune & Stratton, 1960.

Clinical Cardiopulmonary Physiology, edited under the chairmanship of Burgess L. Gordon, is an excellent encyclopedic work covering the growing field of cardiorespiratory physiology. This is a greatly expanded edition and presents not only the basic information related to the subject but also the more recent information derived from continued laboratory and clinical investigations.

The present volume is divided into 12 sections: four related to normal and abnormal cardiac physiology, six related to normal and abnormal pulmonary physiology, one related to the physiological aspects of esophageal and mediastinal disease, and the final one on the relationship of special environmental influences to cardiopulmonary physiology. Each section is complete within the limits of the space allotted, and selected bibliographic references are added to further enhance the value of each presentation. Numerous illustrations in each chapter add markedly to the ease of understanding of the material presented. Of course, as with all multiauthorship books, some repetition and conflict of ideas occur in the various sections. This is a small price to pay for having such a fund of essential information readily available in one volume.

The final section on special environmental influences covering atmospheric pollution, altitude physiology, underwater swimming and submarine operations, and blast and thermal changes is of interest to all physicians. Theoretical as well as practical questions, such as who may safely undergo air travel, are amply discussed in an authorative and interesting manner. The volume may be highly recommended to all with either an investigative or clinical interest in the cardiopulmonary fields.

Thomas W. Shields, M.D.

The Concise Encyclopedia of Modern Surgery. James H. Rutledge. $8. Pp. 308. Philadelphia, Chilton Company, Book Division, 1960.

This book cannot be recommended to readers of this Journal. It is too oversimplified for the medical profession, too technical for patients, and too incomplete for science writers and nonmedical scientists.

The author, a practicing Illinois surgeon, is to be complimented for his persistence in writing the volume and drawing its 140 illustrations. It is unfortunate that he did not direct his work at a single group. This lack of focus commits his labors to inutility. In attempting to explain the medical profession, its specialties, and its total field of surgery and related sciences he has overreached himself. His product, *The Concise Encyclopedia of Modern Surgery,* is concise but it is neither encyclopedic nor modern.

John J. Bergan, M.D.

Learning makes a man fit company for himself. — *Young*



Use of pHisoHex for washing the skin augments any other therapy for acne — brings better results. Now, pHisoAc Cream, a new acne remedy for topical application, suppresses and masks lesions — dries, peels and degerms the skin. Together, pHisoHex and pHisoAc provide **basic** complementary topical therapy for acne.

pHisoHex, antibacterial detergent with 3 per cent hexachlorophene, removes soil and oil better than soap — provides **continuous** degerming action when used often. pHisoHex is nonalkaline, nonirritating and hypoallergenic.

When pHisoAc Cream is used with pHisoHex washings, it unplugs follicles, helps prevent development of comedones, pustules and scarring. New pHisoAc Cream is flesh-toned, not greasy. It contains colloidal sulfur 6 per cent, resorcinol 1.5 per cent, and hexachlorophene 0.3 per cent in a specially prepared base. pHisoAc is pleasant to use.

A new "self-help" booklet, **Teen-aged? Have acne? Feel lonely?,** gives important **psychologic first aid** for patients with acne and describes the proper use of pHisoHex and pHisoAc. Ask your Winthrop representative for copies.

pHisoAc is available in 1½ oz. tubes and pHisoHex is available in 5 oz. plastic squeeze bottles and in bottles of 16 oz.

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RAndolph 6-5794

Pleural effusion

The present study is a report of 15 cases of pleural effusion, probably of tuberculous origin, subjected to a combined therapy of streptomycin, isoniazid, and prednisone.

The great incidence of the tuberculous etiology of such instances is discussed and the advisability of specific treatment in order to avoid relapse is advocated, especially of pulmonary localizations. The paramount importance of prompt resorption of the exudate as a prophylaxis of subsequent functional disorders is stressed. According to the authors' point of view, both requirements are fulfilled by the therapeutic procedure they used. The resorption of pleural effusion took place in the patients, between ten and fifteen days; in 8, between sixteen and thirty days; in 3, between thirty-one and forty-five days, and in 2 at the end of the above period of time. In spite of the small number of patients treated, the authors suggest combined treatment with prednisone and specific antimicrobial drugs in cases of pleural effusion of confirmed or suspected tuberculous etiology. *Newton Bethlem, M.D., et al. Corticosteroid Hormones in the Treatment of Pleurisy with Effusion. J. Lancet. January 1961.*

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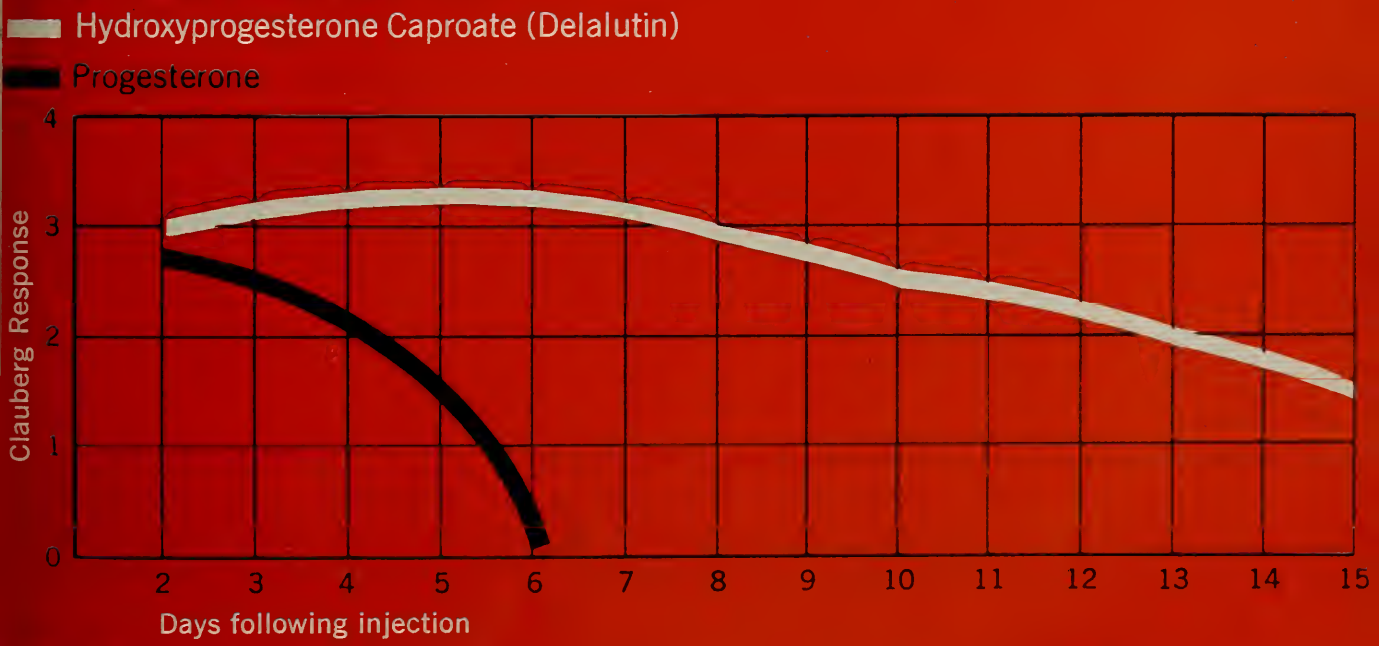
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Dorman, A.: Laboratory Report on the Duration of Action of 17-Alpha-Hydroxy-progesterone-n-Caproate (Delalutin). The Squibb Institute for Medical Research, May 17, 1955.

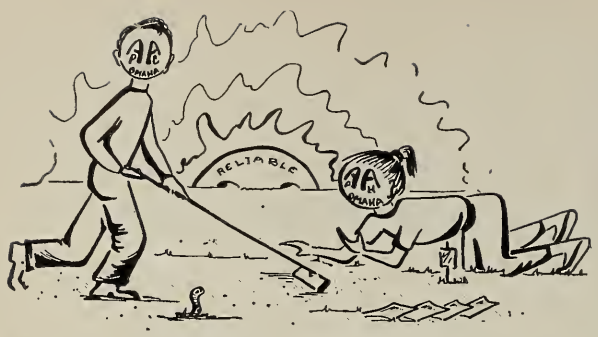


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Complete information on administration and dosage is supplied in the package insert and in your Squibb Product Reference and Product Brief

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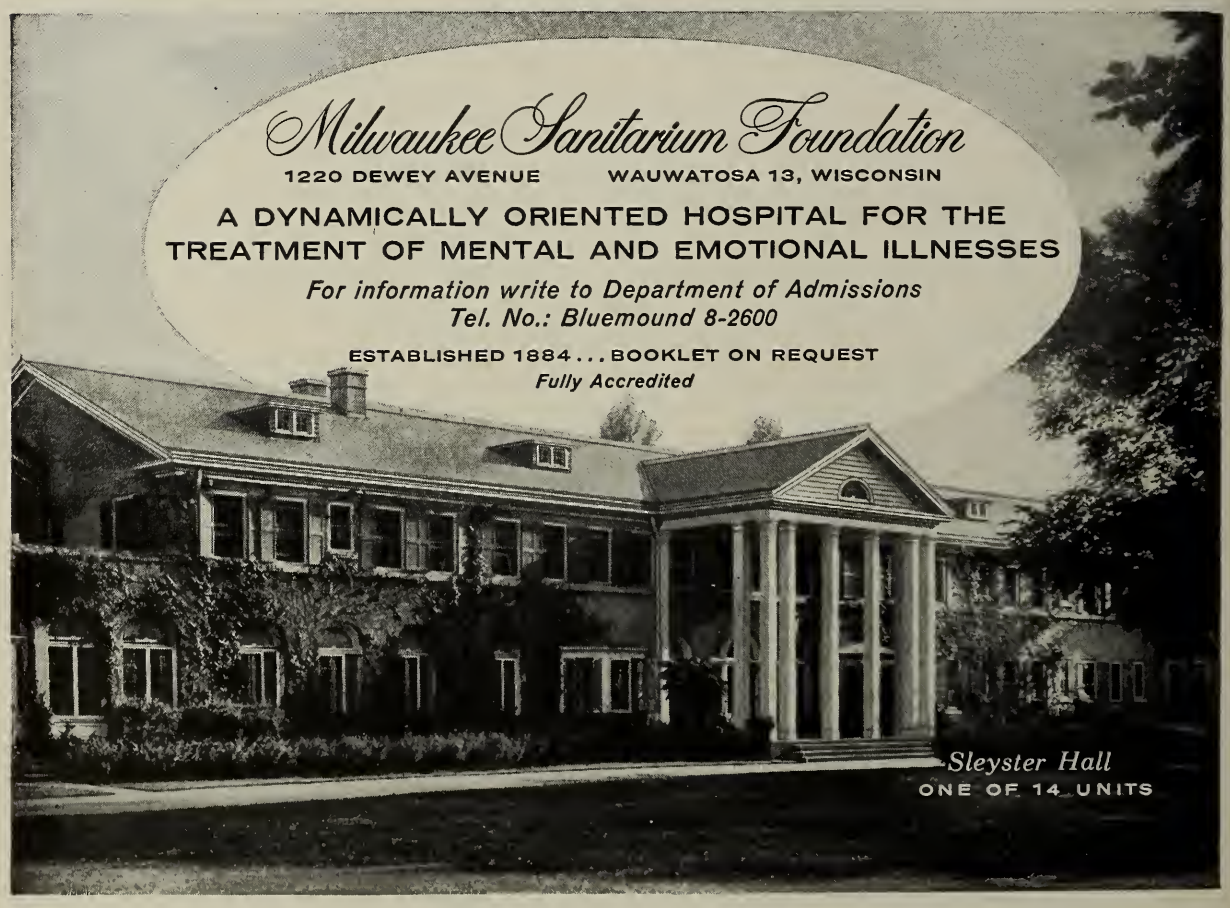
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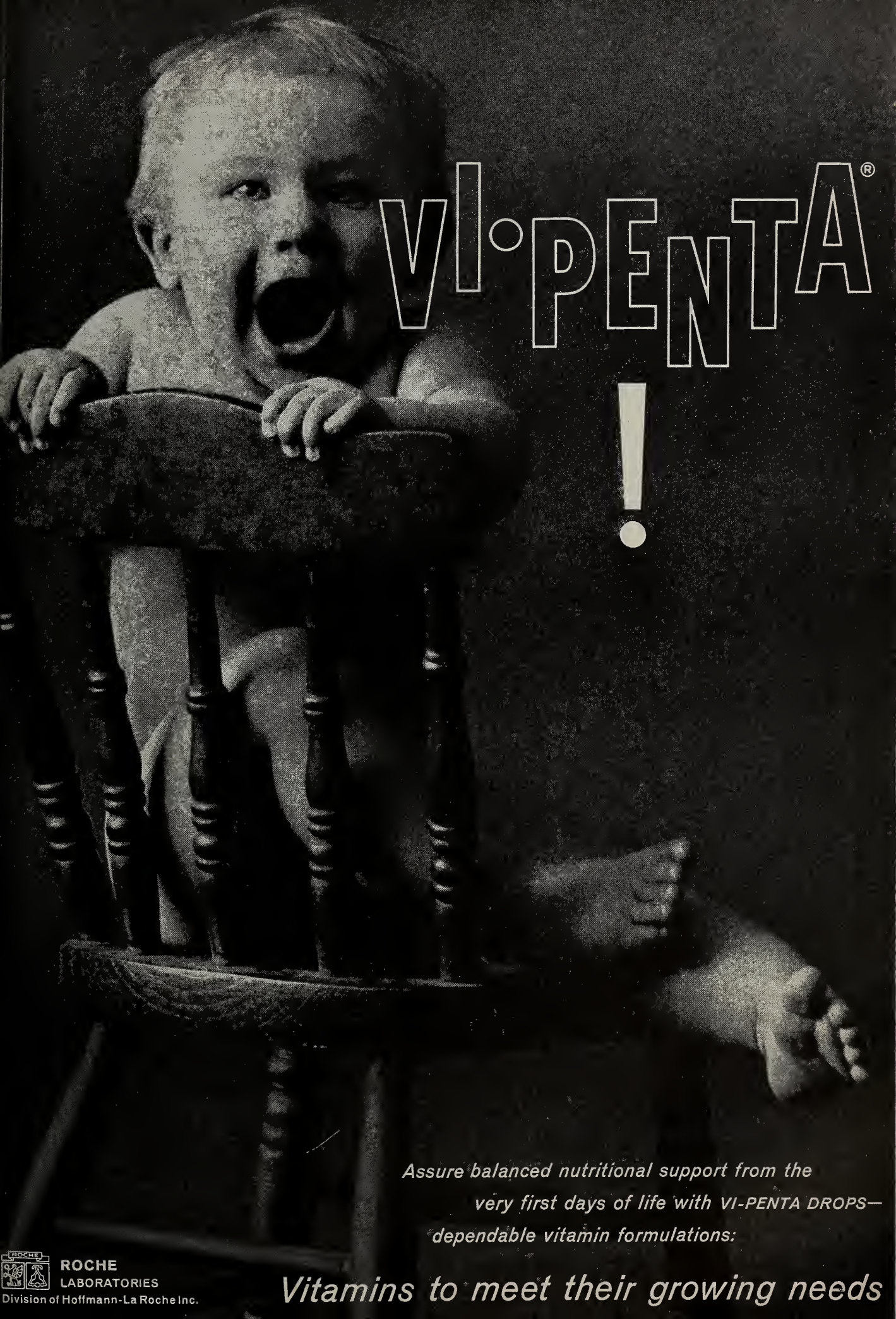
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Infections and asthma

Since asthma, particularly in children, seems to be associated so often with infection, you might be interested in the results of cultures taken from the nasopharynx and the bronchi of a small number of children. The same pathogens were obtained from the nasopharyngeal and the bronchial culture in 20 per cent. In 10 per cent some pathogens present in the nasopharynx were not present in the bronchi. In 29 per cent there were pathogens in the bronchi only. In 2 per cent there were the same pathogens in the nasopharynx and the bronchi, but additional ones in the bronchi. This limited series indicated that the nasopharynx cultures showed only part of the picture, and that in a significant number of patients certain pathogens were found only in the bronchi. This is important when considering vaccine therapy for asthma. *Emily Lois Van Loon, M.D. The Bronchoscopist Views Asthma. Pennsylvania M. J. January 1961.*

Falsehoods not only disagree with truths, but usually quarrel among themselves. — *Daniel Webster*





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Liquefaction of pus

Liquefaction of pus by these proteolytic enzymes has led to their use in combination with antibiotics for treatment of pleural abscesses and empyema, which involve the accumulation of pus in the chest cavity and the lungs. These enzymes have proved their usefulness also in certain gynecologic complaints in which purulent discharges are a factor.

One of these debriding agents is Elase, a product combining the two enzymes, fibrinolysin (plasmin) and desoxyribonuclease (DNA-ase). Plasmin is a gentle proteolytic enzyme which hydrolytically changes fibrinous exudates into simpler molecules. DNA-ase is specifically active against desoxyribionucleic acids and desoxyribonucleoproteins. These latter substances are contained and released from necrotic cells as dead nuclear material and comprise approximately two-thirds of the bulk of pus. Reduction of these molecules into polynucleotides results in a marked thinning effect on purulent exudates and greatly facilitates their removal from wounds. It is important to remember that DNA-ase specifically affects nuclear materials and these materials can only be exposed to the enzyme when the cell wall is damaged—in other words when the cell is dead. *Advances in Drug Research. Enzyme Therapy — An Important New Era in Medicine. South Dakota J. Med. & Pharm. January 1961.*

Ventricular drainage

Since the beginning of modern surgery, recorded attempts to remedy the problem of hydrocephalus have met with frustration and disappointment. Draining off or shunting of cerebral spinal fluid into every conceivable organ or cavity of the body has been tried, with varying degrees of disappointment. By far, our most gratifying results to date have resulted from the development of a minute and seemingly permanent valve that controls spinal fluid drainage from the ventricular system directly into the major vessels of the heart. *Robert Watson, M.D. Neurosurgery. J. Arkansas M. Soc. January 1961.*



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Kestler reports in J.A.M.A. (April 30, 1960) that conventionally treated low-back syndrome patients required an average of 41 days for full recovery (range: 3 to 90 days). The addition of Soma therapy in this comparative investigation reduced the average to 11.5 days (range: 2 to 21 days). With Soma, patients averaged full recovery 30 days sooner.

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The naked nuclei

In recent years it has been accepted that nucleic acid is the guiding factor in genetics, and work on bacterial viruses has produced evidence to substantiate this.

The world at large is not yet aware of what this means. That we have reached the point where we can study life in terms of molecules is in itself a marker of history bearing more weightily on human destiny than the hydrogen bomb or our rockets into space. Ultimately the consequences—for good or ill—are likely to be greater.

Much if not all of mankind's illness is due to sick cells, and much of this sickness is due to nucleic acid having gone bad. Since man can manipulate the nucleic acid in naked nuclei . . . it is not too much to expect that some day he will manipulate the nucleic acid in whole cells in intact living bodies. *Thomas M. Rivers, M.D. The National Foundation Annual Report 1959.*

Men who know themselves are no longer fools; they stand on the threshold of the Door of Wisdom. — *Havelock Ellis*



We used to go to the seashore until his doctor put him on a salt-free diet.

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1. Barden, F. W., et al.: J. Maine M. A. 46:99, 1955.
2. Ford, R. A., and Blanchard, K.: Journal-Lancet 78:185, 1958.

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PHYSICIANS SEEKING LOCATIONS IN ILLINOIS — are notified to contact the Physician's Placement Service in the office of the Illinois State Medical Society, 360 N. Michigan Ave., Chicago 1, Illinois. A file listing communities seeking physicians is maintained. There is no charge for this service of the Society.

WANTED: Locations for locum tenens Taking a vacation? Contact Physicians Placement Service of Illinois State Medical Society, 360 N. Michigan Ave., Chicago 1, Illinois, for list of available physicians. No fee.

1700 BED PROGRESSIVE HOSPITAL-GENERAL PRACTITIONER with PSYCHIATRIC experience — salary $10,635 to $12,210: extra allowance of 15% if Board certified. Write: Manager, Veterans Administration Hospital, Danville, Illinois. 5/61

WANTED: Pediatrician, OB/Gyn, Orthopedic Surgeon, Gastro enterologist, Allergist to join 16-man Clinic. Starting salary $16,000-$18,000. Partnership status after one yr. Weber Medical Clinic, 600 E. Main St. Olney, Ill. 8/61

A.S.C.P. registered young male with dependents would like to relocate in the vicinity of Chicago or within 100 miles. Desires opportunity to build up clinic, private lab., or small hospital. Willing to accept responsibility. Recommendation of three pathologists upon request. Box 328, Ill. Med. Jl. 360 N. Michigan, Chicago 1, Ill.

Perforation versus deflections

Every otolaryngologist who might have considered the surgical correction of the deflected nasal septum of trifling import should re-examine his reflections. Surely, every surgeon who does this operation will have an occasional perforation; but very rarely will he find a patient who would be willing to exchange his perforation for his old deformed septum. Just as surely will he have the unusual case in which there is no improvement; but this will only depress his spirits momentarily. A little musing on the many improved patients will quickly renew his spirits. *Wesley C. Thomas, M.D. Submucous Resection of the Nasal Septum: Special Reference to Anesthesia. South. M. J. November 1960.*

The only true happiness comes from squandering ourselves for a purpose. — *John Mason Brown*

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Abstract of House of Delegates

Annual Meeting May 14-18, 1961

TO: Delegates, Alternate Delegates, Officers and Councilors, Presidents and Secretaries of County Societies.

In order to advise the entire membership of the Society on actions taken by the 1961 House of Delegates, an abstract based on unoffical notations has been prepared. Use of similar inserts in the Journal is one of the means of communication between headquarters and the membership which will be continued whenever important policy making sessions of the HOUSE OF DELEGATES are held. A mimeographed copy was mailed to all delegates, alternate delegates and officers of the State and county medical societies within a week following the annual meeting.

Jacob E. Reisch, M.D.
Secretary-Treasurer

REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND COUNCILORS

Rapport with Paramedical Groups -- Spokesmen for ISMS

A suggestion by the president, H. Close Hesseltine, was endorsed to the effect that ISMS should establish rapport with paramedical groups, other professional societies, and make the best possible use of physician-members as "ambassadors of good will" with these organizations.

The House also concurred in the president's suggestion that offical spokesmen for ISMS be kept well informed and be carefully selected by a special committee. Speeches for TV or radio appearances will be carefully screened for the speakers' protection as well as for the protection of the profession.

Liaison with County Societies -- Secretary-Treasurer's Conference

A recommendation of the Secretary-Treasurer, Jacob E. Reisch, that more efficient liaison between the headquarters office and the county society secretaries should be developed, was approved. Endorsed also was a suggested secretary-treasurer's conference to establish more unified county records and membership procedures. A manual for secretaries and treasurers will be developed to establish better business management procedures.

Study of Medical Service Areas

President Edwin S. Hamilton was requested to appoint a committee to report to the Council on the development of "medical service areas." Mr. Richards was authorized to continue his study activity, in hopes that eventually all areas in Illinois will have "secretarial staff and field services."

Social Security Poll Authorized

A committee is to conduct a state-wide poll on whether or not physicians wish to be covered by social security. Results are to be made available to the House of Delegates and to the American Medical Association.

REFERENCE COMMITTEE ON CONSTITUTIONAL COMMITTEES

Appreciation to Auxiliary

Woman's Auxiliary was thanked for its continued interest in and support of THE BENEVOLENCE FUND. Importance of activities of this committee, the assurance it gives to needy physicians, widows, widowers, and dependent children was stressed.

Active, Continued and Unified Support of S.B. 197 (Kerr-Mills)

Committee on Medical Service was commended for its untiring efforts in behalf of the citizens of Illinois. The House endorsed active support of S.B. 197.

Use of Uniform Claim Forms

As developed by the Health Insurance Council, the House approved uniform claim forms. Physicians required by insurance companies to fill in other forms should feel justified in charging additional fees for additional work.

Encouraged Public Relations

Committee was asked to continue the program of education of physicians and to develop actual and sustained participation on the part of members in Society activities.

ISMS Non-Partisan

A resolution was approved which established as a matter of record that the Illinois State Medical Society is a non-partisan organization.

Third Party Negotiation

A policy was approved that if or when it should become necessary for ISMS to negotiate with third parties relative to conditions of the practice of medicine, the Council should appoint an ad hoc committee from its membership and from the membership at large. These members should be conversant with the practice of all specialties within the state, and should study and explore the problem before a contractual decision is reached.

Citizenship Desirable for Licensure

Every practicing physician licensed by the State of Illinois should become a citizen of the United States. It is hoped that ISMS will be able to amend HB 140 to deny any individual the privilege of renewing his license to practice if he has deliberately neglected his duty and privilege to establish his citizenship at the earliest possible date.

Corporate Structure for Business Purposes

Enabling legislation whereby corporate structures for the practice of medicine could be established for business purposes was endorsed. A model act developed by the AMA in 1957 following favorable action at the national level was

cited as generally acceptable.

New Medical School Possibility Endorsed

APPROVED in principle was the activities of the Foundation for Human Ecology of Park Ridge (an arm of the Lutheran Church) designed to establish a medical school in the area under the sponsorship and guidance of the Lutheran Church.

REFERENCE COMMITTEE ON CONSTITUTION AND BYLAWS

Rewrote the Purposes of the Society Including:

"The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care."

Modified ARTICLE X -- Dues and Expenses

Made it possible for "teaching, research and administrative members in the full time employment of any of the approved medical schools to enjoy full membership at a 50% rate upon nomination by the dean of the medical school, and upon recommendation of the county medical society."

The Council was authorized to give similar consideration on an individual basis to members engaged in full time teaching in a not-for-profit institution, upon recommendation of the county society.

Physicians approved for membership after June 30, shall pay one half dues for that year.

Physicians in the private practice of medicine may be given a 50% reduction in dues during the first year of practice upon the recommendation of the county medical society.

REFERENCE COMMITTEE ON REPORTS OF COUNCIL COMMITTEES #1

I.P.A.C. Committee Is Advisory Only

The House asked that the membership be informed of the true role of the Advisory Committee to the Illinois Public Aid Commission. In its relationship to the Commission it can ONLY RECOMMEND such actions as will most satisfactorily accomplish the mutual aim of physicians and the commission to provide essential medical services at a minimum cost within the medical care budget. It was also called to the attention of the House that participating physicians in Cook County are not paid by I.P.A.C. for hospital services provided directly by them in the private hospitals -- although they are paid for office visits and services and home calls. The ISMS Advisory Committee has concurred in the recommendations of the Cook County Committee that payment for these services should be made.

Encourage Medical Assistants Association

It was agreed that every effort should be made to assist the Medical Assistants Association, to promote its expansion and to guide its activities. The fact that this is an ethical and cooperative group with the best interests of physicians foremost in its considerations was emphasized.

Improve Forensic Medical Knowledge

The Coroners Committee was asked to make every effort to improve the services of the coroners' offices throughout the state in light of modern forensic medical knowledge.

Non-Service Connected Care Discouraged

Veterans continue to be a special class of citizen in relation to medical services for non-service connected illness and injury. The House asked that the practicing physician continue to use his best influence and professional competence to provide the most thorough medical services to all people, and to RESTRICT REFERRAL to VA hospitals to those non-service connected disabilities WHOSE FINANCES ARE SUCH THAT ADEQUATE CARE IS ONLY AVAILABLE THROUGH THESE SPECIAL FEATURES.

Auxiliary Praised

The Auxiliary was praised for its fine support in politics, and social relationship. ISMS should never underestimate the power and influence the Auxiliary can wield in the present effort to stem the tide of reckless abandonment of established principles.

REFERENCE COMMITTEE ON REPORTS OF COUNCIL COMMITTEES #2

A.M.E.F. and Medical School Giving Commended

Reference Committee commented that the dues structure of the Society, and voluntary giving to the American Medical Education Foundation and to Illinois medical schools had provided over $500,000 during 1960.

Aging Program Praised

Activities of the Committee on Aging were highly praised. The report of the committee was factual, and demonstrated not only its interest in the problem, but established an excellent summary of what Illinois physicians are doing to bring about a successful program to provide MEDICAL CARE FOR THE AGED.

Council Asked to Inform and Consult Membership

The Council was asked to consult with and inform society members to the greatest possible extent in all important matters, and NOT TO MAKE POLICY DECISIONS EXCEPT IN EMERGENCY SITUATIONS.

Cancer Detection Program Endorsed

The Cancer Society's film "Time and Two Women" was approved for lay showing throughout the state. It was verified that there was no shortage of pathologists and technical help to study smears on a large scale, and such procedures are recommended in the office of the private physician.

Heart Program Supported

Programs of the Chicago Heart Association and the Illinois Heart Association were endorsed. County society cooperation was requested.

Continued Endorsement of Impartial Medical Testimony

Importance of continued activity on the part of the Committee on Impartial Medical Testimony and the hope that the principle of impartial medical testimony eventually will be used in all of our courts was stressed.

REFERENCE COMMITTEE ON REPORTS OF COUNCIL COMMITTEES #3

Illinois Association of the Professions Recommended

Consideration is to be given to developing an ILLINOIS ASSOCIATION OF THE PROFESSIONS similar to the Michigan pattern in lieu of the present Interprofessional Council. The House expressed its pleasure that Dr. Frederick H. Falls was elected to receive the 1961 DISTINGUISHED SERVICE AWARD by the Illinois Interprofessional Council.

Relative Value Study to be Conducted

In representative areas data is to be developed as a preliminary relative value index for Illinois -- copies of the preliminary study are to be sent to all members of the House of Delegates, to specialty societies in Illinois clearly marked "Preliminary Proposal, Confidential." The material is to be submitted to the House of Delegates for approval before general distribution.

Code Department of Mental Health

Legislation proposed in House Bill 951 and 952 which would establish a Code Department of Mental Health for the State of Illinois, and provide for the care of the mentally retarded children was approved in principle.

Interprofessional Code for Physicians and Lawyers

Approval was received for a code presented to the House. Continued cooperation to develop such changes as may realize improvements in the future, and foster close understanding between the professions was suggested.

Nursing Problem One of the Most Acute

"The success of a physician in the care of his patients is determined by the good quality of nursing, especially in hospital practice. The present confusion in the nursing problem needs vigorous and constructive leadership, heavily weighted by that of the medical profession."

Establish Firm Relationship with the Illinois Hospital Association

House endorsed six suggestions to improve relationship with the IHA:

1. Cooperate with the IHA and other parties interested in health insurance.
2. Establish well defined policies with regard to the aims of organized medicine.
3. Detail a committee to promote current concepts at general meetings.
4. Tape-record or monitor meetings and workshops so that new thoughts can be carefully analyzed.
5. Establish communication with labor, industry, insurance and hospitals toward the goal of developing future policies.
6. Formulate a health insurance code.

REFERENCE COMMITTEE ON REPORTS OF COUNCIL COMMITTEES #4

Encourage Preventive Services by I.P.A.C.

Committee on Poliomyelitis Control was commended for its request that physicians continue to give vaccine to children under the Aid to Dependent Children program, even though the Illinois Public Aid Commission does not provide payment. The I.P.A.C. should be encouraged to provide preventive medical services.

Approved Recommendations of the Committee on School Health

Dealing with body-contact sports, the House endorsed (1) Schools should NOT INCLUDE BODY-CONTACT SPORTS (particularly tackle football and boxing) for children of school age THROUGH THE NINTH GRADE. (2) Agencies sponsoring athletic activities outside of school programs should be required to provide for competent medical supervision.

It was further commented that until such time as body-contact sports in the elementary and junior high schools can be eliminated, THE MEDICAL PROFESSION HAS AN OBLIGATION TO GIVE ALL POSSIBLE ADVICE ON HOW TO MANAGE SUCH PROGRAMS.

New Section Established on Physical Medicine

The House established a new section on Physical Medicine. This brings the total number of sections to thirteen.

SPECIAL REFERENCE COMMITTEE REPORT

Income Tax-Deferred Pension or Retirement Plans to be Studied

After consideration by a special committee, the House authorized the COUNCIL to appoint a committee to be charged with the responsibility of investigating the problem and to prepare recommendations for the approval of the Council with respect to establishing a TAX-DEFFERED PENSION OR RETIREMENT PROGRAM FOR MEMBERS OF THE ILLINOIS STATE MEDICAL SOCIETY. Prior to the implementation of any such plan, it is to be reported to the House.

MISCELLANEOUS ACTIONS

1961-1962 Officers and Councilors

Following the elections held on Thursday morning, May 18, the official family of the ISMS was established for the 1961-1962 programs as:

President:	Edwin S. Hamilton, Kankakee
President Elect:	George F. Lull, Chicago
1st Vice President:	William H. Whiting, Anna
2nd Vice President:	Eugene T. McEnery, Chicago
Secretary-Treasurer:	Jacob E. Reisch, Springfield
Presiding Officer:	Walter C. Bornemeier, Chicago
Assistant Presiding Officer:	Harlan English, Danville

The Council remains the same: William E. Adams and John Lester Reichert of Chicago were re-elected; Fred C. Endres of Peoria, Jacob E. Reisch of Springfield, Arthur F. Goodyear of Decatur, and Harlan English of Danville were also re-elected.

Effective JANUARY 1, 1962 the Delegates and Alternate Delegates to the AMA will be:

Delegates	Alternates
H. Kenneth Scatliff	Eugene T. McEnery
Walter C. Bornemeier	George C. Turner
Frank H. Fowler	E. A. Piszczek
Maurice M. Hoeltgen	H. Close Hesseltine
Leo P. A. Sweeney	Raleigh C. Oldfield
Carl F. Steinhoff	Norris J. Heckel
Arthur F. Goodyear	Newton DuPuy
Harlan English	Jacob E. Reisch
E. W. Cannady	Carl E. Clark
Harry Mantz	Paul A. Dailey
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DUES FOR 1960 TO REMAIN THE SAME--$80.

Of this amount, $58 is to be allocated to the general fund, $2 to the Benevo-

lence Fund, and as in the Past $20 to the A.M.E.F.

▶ Eight Resolutions To Be Presented By ISMS Delegates To The House of Delegates of The American Medical Association--June New York Session

1. Illinois delegates to the AMA will introduce a resolution requesting that the Joint Accreditation Commission exercise greater care in the selection of its hospital examining personnel, and that a consultation with the staff officers be held before adverse decisions are rendered.

2. The House of Delegates of the AMA will be asked to concur in the action of ISMS that the proper conduct of laboratory analyses is a medical professional responsibility, and all specimens for such analysis should be referred to laboratories supervised by fully qualified and licensed physicians.

3. Since many general practice residencies are unfilled and many have inadequate progressive and integrated training programs, the House of Delegates of the AMA is to be requested to render full cooperation to the American Academy of General Practice to develop improvement of this situation.

4. ISMS will ask that the AMA House establish a commission or a sub-committee on the relationship of medicine to optometry.

5. ISMS delegates will urge the AMA to recommend that other state medical societies join the United States Chamber of Commerce, and support that organization to the end that "the free enterprise system will be strengthened in America."

6. ISMS will request the AMA House to inquire of the Federal Aeronautics Administration the reasons for rejections of physicians giving the Class II and Class III flight examinations for private air pilots, especially since these examinations require no special equipment or training.

7. ISMS delegates will express appreciation to the AMA for efforts in Washington to prevent the passage of legislation similar to the Forand type.

8. ISMS delegates will introduce and support a resolution which will give consideration to the discontinuance of the scientific portion of the clinical session of the AMA usually held in December of each year.

▶ Presentation of AMEF Checks

Dr. George F. Lull, president of the American Medical Education Foundation, presented checks totaling $141,650 to representatives of the five medical schools in the Chicago area. Chicago Medical School, represented by Dr. Andrew H. Ryan, Vice President of Student Affairs and Dean of Students ($25,879); Northwestern University Medical School, represented by Dr. Richard H. Young, Dean, ($35,737); Stritch School of Medicine, represented by Dr. John F. Sheehan, Dean, ($26,475); University of Chicago, represented by Dr. Robert G. Page, Assistant Dean, (20,571); and the University of Illinois College of Medicine, represented by Dr. Granville A. Bennett, Dean, ($32,988).

▶ Representation from SAMA

The five chapters of Student American Medical Association sent official representatives to the opening meeting of the House of Delegates. Chicago Medical School: Mr. Laurence Seigler; Northwestern University Medical School: Miss Sandra Jane Forbes; Stritch School of Medicine: Mr. Joseph DeFiore; University of Chicago: Mr. Robert Ridley; University of Illinois College of Medicine: Mr. John R. Shepherd.

▶ Presentation of Outstanding General Practitioner Award

Dr. William Ernest Carnahan, Macomb (McDonough County) a 76 year old physician who has practiced medicine in McDonough County for 46 years, was awarded the ISMS certificate and an illustrated historical account of his services to the public by Dr. H. Close Hesseltine. Doctor Carnahan was named the "General Practitioner of the Year" by the Illinois State Medical Society for 1961.

Frances Zimmer Honored

Mrs. Frances C. Zimmer was honored by the ISMS for 25 years of service with the Society. Dr. Edwin S. Hamilton of Kankakee, president-elect of the Society, presented Mrs. Zimmer with a silver tray and coffee service. Doctor Hamilton represented the Society as the only officer or councilor active at this time, who was a member of the Council at the time Mrs. Zimmer was employed.

Sherman Hotel Selected for 1962 and 1963

The House approved the recommendation of the Council that the 1962-1963 meetings be held at the Hotel Sherman, and that the 1964 session be held in Chicago. For 1962 the dates are May 13-17; for 1963 the dates are May 12-16.

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Vol. 119, No. 6 **June, 1961**

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Published monthly by the Illinois State Medical Society, 360 N. Michigan Avenue, Chicago 1, Ill. Subscription $4.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, Hawaiian Islands, and Mexico. $6.00 per year for all foreign countries included in the postal union. Canada, $4.50. Single current copies 50 cents. By mail, 60 cents.

Second class postage paid at Mendota, Illinois. POSTMASTER: Send notices on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago 1, Ill.

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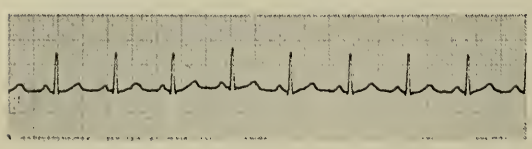
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The Month in Washington



The American Medical Association labeled untrue certain statements by Abraham Ribicoff, Secretary of Health, Education and Welfare, concerning the Administration's legislative proposal to provide medical care for the aged under Social Security.

Dr. F. J. L. Blasingame, AMA executive vice president, presented a point-by-point rebuttal in a letter to the more than 500 editors throughout the country after Ribicoff addressed the annual meeting of the American Society of Newspaper Editors in Washington.

Dr. Edward R. Annis, Miami surgeon representing the AMA, accused Ribicoff of misrepresenting the role of doctors under the administration proposal. Dr. Annis answered Ribicoff on a radio-television program with Sen. Kenneth B. Keating (R., N.Y.) which was taped in Washington. Ribicoff had made the misrepresentation on an earlier Keating program.

Dr. Blasingame said Ribicoff's statement before the editors that physicians are not included in the administration proposal, the King bill, "simply is not true." He pointed out that the bill includes interns and residents in teaching hospitals as well as pathologists, radiologists, physiatrists, and anesthesiologists working in hospitals or serving hospitals' outpatient clinics.

"Mr. Ribicoff further claims that the King bill provides free choice of hospital physician," Dr. Blasingame said. "The fact is only hospitals signing contracts with the federal government would be available to patients. If the only hospital in a community was not approved by the Secretary of HEW, patients in that community would be forced to seek hospitalization in some other city. That would not afford free choice of hospital. If the patient's physician was not on the staff of the other hospital, the patient would be denied free choice of physician."

Dr. Blasingame also disputed Ribicoff's contention that the King bill is not socialized medicine. "By common definition, any scheme which calls for a system of compulsory health care which is administered, financed, and controlled by the federal government is socialized medicine for that segment of the population it serves."

Rep. Walter H. Judd (R., Minn.), a physician and one of a number of House and Senate members who agree with the AMA, said, "The public has been led to believe that they can get government financing without government control and ultimate government operation of medical services. It is naive for anyone to believe that Congress will take the people's money away from them through taxes and then allow the money to be spent by someone else without the Congress maintaining its own firm control."

Pointing out that the nation's physicians always have been in favor of medical care for all regardless of ability to pay, Dr. Blasingame said, "It seems strange to us that Mr. Ribicoff continues to lobby for the King bill while complete-

(*Continued on page 23*)

ly ignoring the Kerr-Mills law, passed by Congress last year with strong support by the nation's physicians.

"The Kerr-Mills Law enables the states to guarantee to every aged American who needs help the health care he requires. And the states are implementing the law with unprecedented swiftness."

Dr. Annis pointed out on the radio-television program "doctors would work for the government by working for the hospitals under contract to the government." He said those doctors would work "under rules, regulations, and controls prescribed and laid down" by the HEW.

The Department of Health, Education and Welfare has agreed to make an impartial evaluation of the controversial cancer drug Krebiozen.

U.S. District Judge Julius H. Miner of Chicago requested the evaluation before proceeding with a $300,000 libel suit filed by Andrew C. Ivy, M.D., a leading endorser of the drug, against George D. Stoddard, Ph.D., chancellor of New York University and former president of the University of Illinois.

In a letter to HEW Secretary Ribicoff, Miner said, "In my humble judgment, Krebiozen has too long been a controversial subject and the American public deserves that it be examined under neutral supervision and by the most competent experts in whom the people have implicit confidence."

Ribicoff said the National Cancer Institute would evaluate the drug when its sponsors presented the necessary data. But, he said, "Any decision to undertake a study with human cancer patients must await, and depend on, the results of the evaluation of the existing clinical data."

A new bill to encourage physicians and other self-employed persons to set up their own retirement plans started through Congress with approval of the House Ways and Means Committee.

Bearing the same number, H.R. 10, as a similar bill which died in Congress last year, the new measure would permit a self-employed person to defer taxes on income placed in a private

(*Continued on page 37*)

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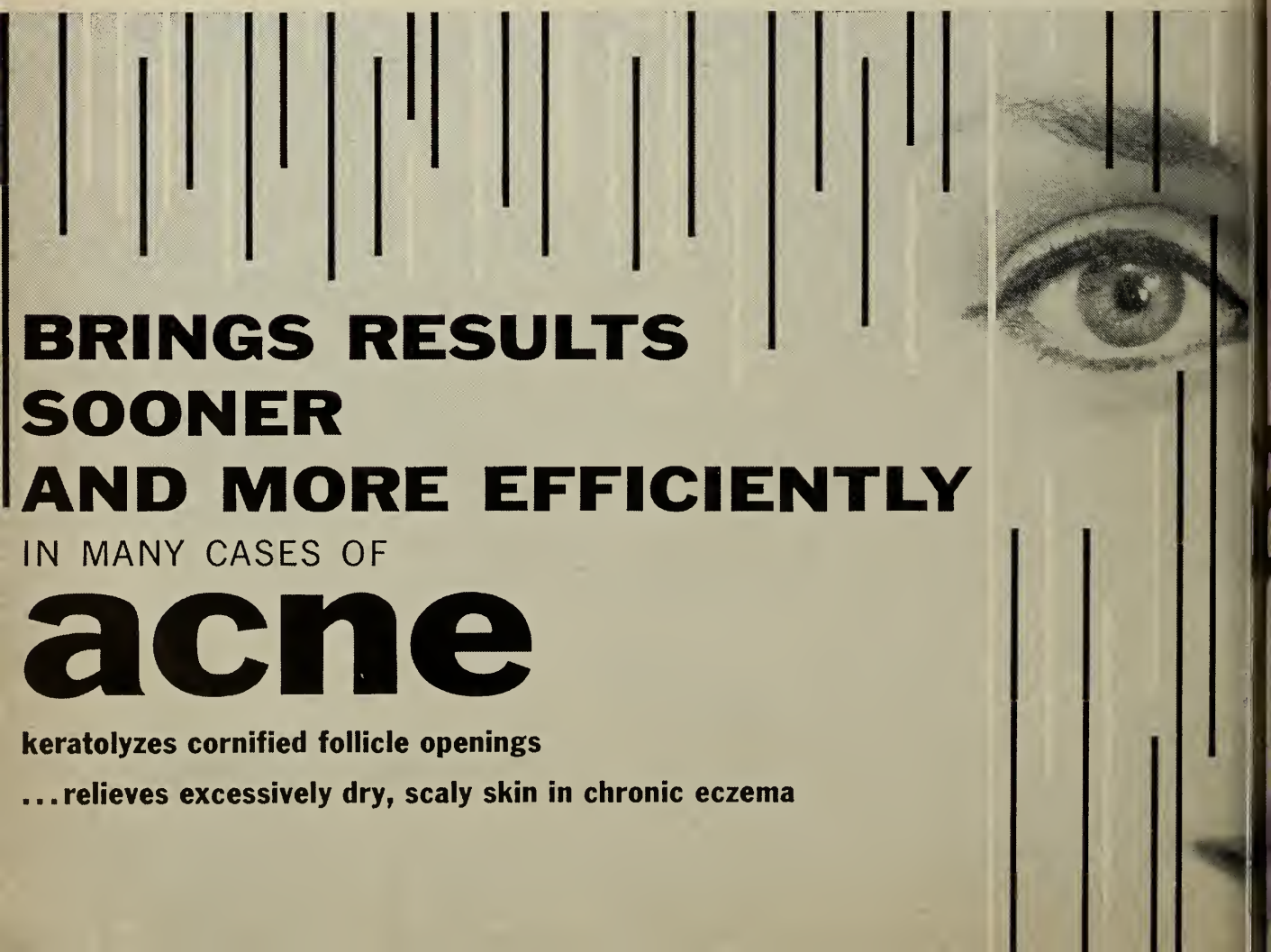
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(Continued on page 36)

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Every gathering of Americans—whether a few on the porch of a crossroads store or massed thousands in a great stadium—is the possessor of a potentially immeasurable influence on the future. — *Dwight D. Eisenhower*

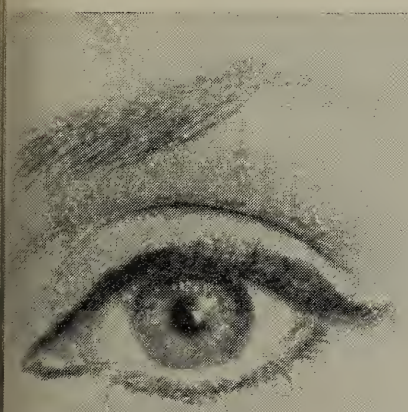
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The ILLINOIS Medical Journal

Official Journal of The Illinois State Medical Society

JUNE, 1961
VOL. 119, No. 6

Are We Nonconformists?*

H. Close Hesseltine, M.D., *Chicago*

Various descriptions and comments on man as a creature of an organization have flowed from the pens of professional writers. His relationship and influence to and with his superiors and peers apparently become stereotyped. Although those at the top preach free speech to those in subordinate posts, preferences are commonly given to those who go along. Documentation is found in the book "The Organization Man" by William H. Whyte, Jr. Even so, he and others point out that "individualists" do and can succeed, too. Whyte wrote about the business world, but organizations, business or professional, have some features in common. The Illinois State Medical Society is an organization. Therefore, our medical society must have some of the same problems.

The original purpose for the formation of our Society was to enhance medical education, elevate professional standards, and foster scientific progress. Today, it is obvious that organized medicine not only has these purposes to support, but in addition, must become aware of and assume its responsibilities in the evolutional changes which include, among other things, sociologic medicine, medical economics, legal medicine, and legislative medicine. The fact that medical sciences are valued, desired, and copied is praiseworthy; but these attitudes cause the ill-informed, the misguided, and the social designers to act too often in ways detrimental to the public health welfare and infringe upon, and thereby interfere with, the prerogatives of the medical and other professions.

The future

The future course of medical practice has been projected in a number of directions; really it will be determined by the summation of events. Thus, its ultimate course can be appreciably influenced, if not directed, by our untiring efforts. History will record precisely and unemotionally our success or failure. Any effective campaign entails perseverance by our members individually and collectively. Collectively, we are the Society. As a society we need and must make friends with individuals and groups to further our causes.

If we are to function as an organization, we must have leaders and we must submit to being led. Brilliant insight of our leaders and loyal unification of our members are cardinal factors for successful competition of this stormy period. The extent of success is correlated to collective strength. Collective strength is proportional to the total effort of the group as a unit; and a unit operation requires conformity.

**President's Address delivered at the 121st annual meeting of the Illinois State Medical Society before the House of Delegates, May 14, 1961.*

Leadership

A society or an organization of merit requires proper leadership and support by those "led." Wise and prudent leaders know the will of the majority (except in new and complicated unexpected situations). Thus, the individuals have a duty to their organization to acknowledge communications from the leader. Obviously, the majority view should prevail under specified circumstances. Digression may be the unquestioned preference when modification alters appreciably the problem or methods of solutions. Thus, decisions made by leaders in rare and exceptional situations must be measured with tempered thought and an abiding confidence by members.

Our medical society is composed of over 10,000 individuals, all of whom have above average intellectual abilities, for they are doctors of medicine. Moreover, these individuals are able to communicate, because they have a successful practice. These members guide, direct, and influence their patients' physical and mental well being. These members, if they use their rights as first-class citizens, may influence the programs of the communities. Yes, the doctor functions as an independent soul in many ways. By the nature of his profession he becomes so.

We could classify ourselves as prima donnas—male, that is—because we are at the front of the professional stage and must make numerous solo decisions. Our medical society is not entirely unlike an opera company. The officers are its conductors. All of you have stellar roles. And are not stars often prima donnas? Yet the production of an opera can be successful when all its components are coordinated, and so may be the results of efforts of a unified organization.

Problems

We have been and most surely will continue to be confronted with vexing and critical problems. We should admit that our successful ministrations have contributed to some of these crises. By virtue of the contributions of medical sciences, we no longer just relieve pain, set fractures, and cure ills. We have extended into rehabilitation, safety promotion, and immunization. The resulting disturbance of the biological balance in human living still fits into the Taoist text . . . "The living and the dead, the going and coming, know nothing of each other's state."

Because of the rapid changes in longevity, we have contributed to an economic imbalance as well, a sociologic dilemma, and emotional unrests. The successful application of modern medical services has made it possible for more people to work and to live longer, but we have not conquered the conditions affecting aging and debilitation. As a result, medicine finds at its doorsteps predatory products of some social scientists and others. These approaches, if carried through to their fickle conclusion, would deprive us of most of our professional freedoms, and more seriously, rob, shamelessly, the public of its right to select quality medical care. Propaganda is subtle and bold. The utilization of smear techniques, untruths, tarnish our professional image. Truth must be focused on these obfuscations for public enlightenment.

Individualism

Dare we to think only of our individual dignity and position? Or must we unite to restore our dignity and prestige as a profession? To operate as a unit or society, each of us must yield some individualism. We must concede that the majority rule and the minority cooperate. What price must one pay, especially when one is in the minority? One could surmise that it would be mostly emotional. The majority should be fair, the minority tolerant, as the "loyal opposition." The next time, those in the minority may be on the side of the majority.

Spokesmen

When any physician talks, even though he speaks as a private citizen and in a private assembly, his remarks may be taken by some as official comments of organized medicine. As a safeguard, it is suggested that each of us states clearly that he speaks as a private citizen. On the other hand, when we speak in behalf of medicine we must be correct and in tenor with the official views of organized medicine.

We must select physicians who can accurately and factually represent us, speak for us, or act for us. We need only look back a few months at some television programs to discern what may happen when spokesmen enter areas in which they do have few skills. Spokesmen for the Illinois State Medical Society should be selected because of skills and competence in delivery. They must be chosen for the particular media

or audience. Each must look the part of a physician and be dressed like one. The conversation, poise, and mannerisms must befit the profession. In other words, voice quality and character, mannerisms, poise, dress, and other attributes should guide the selection. Some physicians can give formal lectures, while others debate better.

It appears that in the future the Illinois State Medical Society will be called upon more and more to supply speakers. They will be in friendly as well as hostile, controversial, and unfriendly groups. The individuals serving us in the competitive areas must be the best we can produce. Should our principal officers carry this burden? I think not. As a matter of principle our officers should be kept on a high position of liaison, and ambassadors-at-large for organized medicine. The bellicose area belongs to our competent verbal combatants.

The Illinois State Medical Society can ill afford to be an island. Paul E. Klopsteg in a discourse on the indispensable tools of science said, "Instruments are unifying elements which help self-centered disciplines shed their isolationism." One of our instrumentalities must be the expansion of our friendships. We must understand other groups, their problems, and enlist their aid for support in legislation and other programs. We may work with any and all groups when our interests are mutual, but we need not alienate any group because we occasionally must take an opposing stand.

Can we make self adjustments to be led or used for the common good? Unfortunately, we do not view ourselves as others do. Perhaps if one forgets oneself, and looks at the others about, the view may clear. How many of your colleagues in what categories of action would you choose for critical areas of "combat" for our Society? Thus, if we eliminate the egos and concentrate on the herd instinct, we may be able to shed our professional cloaks of nonconformity. Paying the price may be less painful.

Growth

What will a peek into the future reveal? Will the physician retain his professional image, yet adjust adequately to a coordinated organization? Our Society should continue its growth and expand its activities. The rate of growth and its nature will be directly related to the submersion of the members' individualism for our Society functions. This acquiescence denies not the right of speech, nor prevents the submission of ideas to the parent body, but it is an essential component of loyal unity. Longfellow phrases it, "All your strength is in your union. All your danger is in discord."

Some of the special problems before us are the care of the needy over age 65; legislative matters at the state and national levels; and the need for enough physicians to care for the exploding population.

Solution

Gentlemen, this much seems certain: Whatever transpires in the future in relation to medicine and medical sciences, you will have had your opportunity to exert a profound influence. This opportunity is not a privilege or favor; it is a right, a duty, and a responsibility. To be effective, you must be united, work together, and persevere.

The question before each of you and those you represent is: Can each member lay aside his professional individualism in working with the Society for the betterment of public welfare? Can you substitute conformity for nonconformity when you toil as members of the organization? In the past, metamorphosis occurred, and the individuals returned to their original state all the more matured. We envision in the days and years ahead these same changes. These dual characters need not be in conflict nor schizophrenic. We may shuttle back and forth from individualism in our practice to conformity as a working member in our Society. We have been accused of being nonconformists. It is my conviction that we possess the faculty of youth and vigor to make the necessary adjustments or transitions. Will you substantiate my opinion?

Summary

In summary, let me emphasize three particular points for your careful consideration:

1. Unless your officers, the House of Delegates, the Council, and the committees have the support of our members their efforts may be fruitless.
2. To insure our unity, which is essential, we must accept individually the concept of "Organization."
3. The official spokesman of the medical society must be selected with sagacious planning.

A Case of Neuromyelitis Optica

Homer B. Field, M.D., *Blue Island*

Neuromyelitis optica (Devic's disease) is a rare condition, and its differentiation from multiple sclerosis is not definite nor universally accepted. As in all the demyelinating diseases — disseminated sclerosis, neuromyelitis optica, or Devic's disease or encephalitis periaxialis diffusa or Schilder's disease — the etiology is extremely obscure. Pathologically the picture is one of early, rather complete loss of the myelin sheaths in isolated foci or in large confluent areas. Until the etiology is established, the absolute classification of these conditions cannot be final.

Differential diagnosis

Neuromyelitis optica, first described by Devic,[1] is characterized by a severe retrobulbar neuritis and a transverse myelitis that is a more characteristic and fulminating than that usually associated with multiple sclerosis. Sorsby[2] points out that it causes greater destruction of the axis cylinders than does disseminated sclerosis; hence, there is a greater loss of vision and function that is permanent. This greater destruction plus the more extensive distribution of the condition and its less sharply defined limits establishes the diagnosis and creates an entity different from multiple sclerosis.

The retrobulbar neuritis usually preceeds the myelitis but sometimes follows it. The interval between the neuritis and the myelitis is usually short but may be several weeks. The optic discs appear normal for the first few days, then gradually show evidence of papillitis which, if persistent, leads to optic nerve atrophy. Even though the patient survives the acute myelitis, vision is permanently destroyed. Visual fields early may assume the nature of any retrobulbar neuritis, depending on the portion of optic nerve or chiasm involved. Diplopia and the ophthalmoplegias are rarely noted. Nystagmus likewise is not seen since the cerebellar pathways are seldom affected. An occasional Horner's syndrome is found.

The immediate prognosis is poor and worse than in multiple sclerosis. If the acute illness is not fatal, considerable recovery may take place but with gross visual and spinal cord impairment.

In the differential diagosis two conditions must be mentioned: multiple sclerosis and Schilder's disease or diffuse cerebral sclerosis which usually occurs prior to age 16. It is sporadic or familial and pathologically is characterized by large areas of demyelinization in the cerebral hemispheres. It usually starts in the occipital lobes and extends forward. It may extend to the brain stem and even into the spinal cord. The cerebrospinal fluid is usually normal but may show a slight increase in protein and, occasionally, cells. Whether this condition is inflammatory or degenerative is undetermined. It may run an acute or a chronic course extending over several years. Loss of vision is early due to occipital lobe involvement. Personality changes, mental deterioration, deafness, aphasia, upper motor neuron paralysis, sensory changes, and ataxia follow in varied order and severity. Though the condition is bilateral, it is not necessarily symmetrical. Remissions are uncommon, and the final state is one of blindness, paralysis, dementia, and incontinence.

Ophthalmologic features of Schilder's disease are those of hemianopsia progressing to blindness. Optic atrophy occurs later in the disease. As the condition progresses, paralysis of extraocular muscles as well as papilledema and increased intracranial pressure are encountered. With involvement of the hemispheres comes visual agnosia, alexia, and loss of optic fixation reflexes, loss of spatial orientation, and paralysis of conjugate movements. The disease is invariably fatal. The course is downhill for at least a year, but some die within 8 to 10 days; others linger for periods up to 15 years.

Neuromyelitis optica is not inherited, and there is no predilection for either sex. The age of involvement is variable, but usually is in the

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Presented before the Section of Anesthesiology, Illinois State Medical Society Annual Meeting, May 24, 1960.

early decades of life. Walsh[3] reported autopsy findings of extensive demyelinization of the optic chiasm and the spinal cord; no gliosis or lesions of the cerebellum were found. The cortex is spared in most cases. Liquefaction and cavitation are common, and while the white matter is affected first, the process continues into the gray matter. There is no explanation for the selectivity of the disease for the chiasm, optic nerves, and spinal cord.

Clinical features

Loss of vision, visual field defects, extraocular muscle palsies, and paraplegia are permanent, but occasional defects that have persisted for a year or two are seemingly overcome. The loss of vision is nearly always bilateral, one eye being involved prior to the other by a few hours to a few days. The loss is rapid and dramatic, in contrast to that produced by space-occupying lesions, and is usually preceded by pain in or about the head. It is generally accepted that the blindness precedes onset of paraplegia, though Goulden[4] reports that in about 20 per cent of cases paraplegia precedes the visual disturbance. Walsh[3] reports only one patient in whom total blindness ensued. His remaining 14 patients recovered their vision partially or completely. There is, as a rule, only one attack involving visual loss.

The appearance of the optic disc is not distinctive. There is usually a low grade papilledema with subsequent pallor and atrophy. Narrowing of blood vessels around the disc has been reported.

Extraocular muscles are not involved as a rule, though McKee and Naughton[5] report paralytic involvement of the conjugate movements of the eyes.

Pupillary response depends on the extent of vision loss. Cortical blindness, i.e., blindness in which pupillary response persists, is not seen. This is in sharp contrast to Schilder's disease.

Visual field changes are not diagnostic because of the variation in the demyelinating processes.

Nystagmus is not seen in neuromyelitis optica, in contrast to its frequency in disseminated sclerosis.

Paraplegia may develop soon or late and may similate a cord tumor at any level of the cord. The involvement may be partial, or a complete, flaccid paralysis. If paraplegia is not too severe, some recovery may take place, but residual defects usually remain. The spinal fluid is not diagnostic; there may be an occasional cell and a slight increase in protein content.

For a complete and concise review of the subject of neuromyelitis optica, the reader is referred to the section in Walsh's "Clinical Neuro-ophthalmology," pages 656-662.

Case report

CC., age 44, a white male, had always enjoyed excellent health, had been unusually active physically, and seldom had seen a physician for any reason. He had an older sister who had died of "meningitis" thirty years before.

Two days prior to his consulting me, he developed a slight headache. This was very unusual. While reading the paper he became aware of blurred vision in his left eye. There was no pain in the eye, no photophobia or other disturbance.

Our examination revealed the following vision: right eye 20/15; left eye 20/70. The refractive error was negligible. Pupillary response and pattern were normal. The ocular media were clear, and the ocular fundi appeared normal. Note was made of a rather deep physiologic cup in each disc.

Visual fields showed a large defect involving the lower half of the field, including the macula, (Fig.1).

A complete neurologic examination failed to reveal any abnormalities. All muscle response, reflexes, and muscle coordination were quite normal, and no sensory disturbances were found.

X-rays of the skull and optic foramen showed no abnormalities.

When seen three days later, the patient had faulty light perception only in each eye. He was admitted to the hospital. On examination the optic discs appeared full, and the physiologic cup was obliterated. No measurable elevation of the discs was found.

A spinal tap was made at the third lumbar interspace. The opening manometric pressure of 240 mm. of water was raised to 280 mm. in 10 seconds by jugular compression. It returned to normal immediately on release of compression. Five cc. of fluid were withdrawn, and 5 cc. of Pantopaque® were injected. The Pantopaque had difficulty passing through the level of dorsal discs 3, 2, and 1. Studies on the tilting table

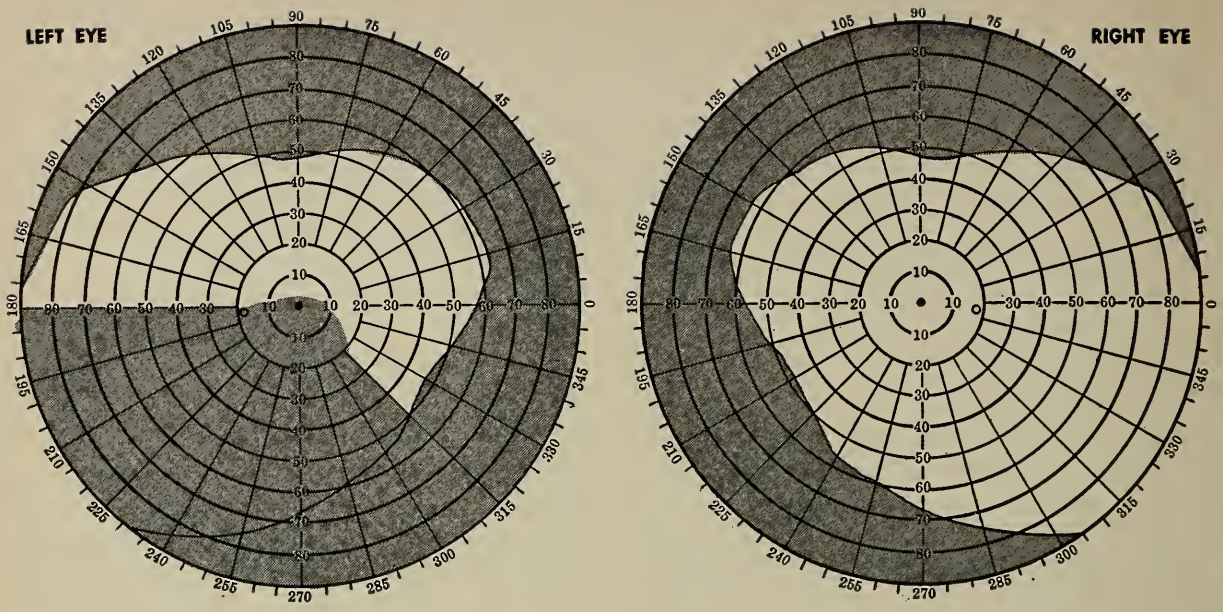


Figure 1. Visual fields showed defect in lower half.

showed an almost complete block at disc 2.

The spinal fluid showed a slight protein elevation, but no cells of any type and no bacterial growth. Twelve days after the onset of his headache the patient began to complain of numbness in his legs and within 24 hours had developed a complete flaccid paralysis of his lower extremities from the level of the third dorsal disc.

An exploratory craniotomy revealed such peculiar thick adhesions between the dura and the frontal bone that sharp dissection was required to free the bone flap. Exposure of the optic nerves, anterior chiasm, and the pituitary failed to reveal any evidence of a space-occupying lesion or of aneurysm. Likewise no cicatricial bands involving the optic nerves and chiasm could be seen. The exploratory craniotomy done on another day corroborated the normal findings in the carotid arteriogram previously taken.

An exploratory laminectomy at the level of the first to third dorsal discs revealed an area of serous arachnoiditis with considerable hyperemia of the cord. Subsequently the patient developed a bladder retention. He has recovered nicely from his surgery.

His present condition is that of total blindness and a complete flaccid paralysis below the second dorsal vertebra. He is mentally alert, and it would seem that the disease is arrested. But the optic discs are completely atrophic, and with a paralysis of this type, showing no improvement, the prognosis for recovery is poor. There is a complete loss of all sensation below the third dorsal vertebra; he has a typical "cord" bladder.

Neurologic examination

The following neurologic consultation was obtained: According to this patient's statement, he went golfing on Wednesday and at that time he caught a cold. Some uneasy feeling in his forehead overlying the eyes he believed was a sinus condition. The following Friday, while golfing, he noted that he could not see the tee clearly. His symptoms became worse by evening, and by Saturday his left eye was almost totally blind. The following Monday his left eye was totally blind, and the right eye became involved and at the time of examination he could not see at all.

He has had some headaches mainly localized in the frontal area, but there are no other complaints, and he denies any dizziness or lack of balance. He does not recall having any serious trouble in all his life and never had any infections or infectious diseases.

Neurologic examination reveals a 44 year old white male in excellent general condition responding well to questioning and oriented well in time and space. Inspection of his head reveals no perceptible pathology nor nuchal rigidity.

TABLE 1. URINALYSIS

DATE	COLOR	TRANSPARENCY	pH	SP. GR.	ALBUMIN	SUGAR	ACETONE	
9/24/59	Yellow	Clear	5.0	1.020	Trace	Neg.	Neg.	
10/1/59	Bence-Jones Urine Protein = Negative							
10/3/59	Yellow	Clear	5.0	1.025	Trace	Neg.	Neg.	Occasional epithelial cell 5-7 cells
10/14/59 Catheterized	Yellow	Clear	5.5	1.020	Neg.	Neg.	Neg.	Occasional hyaline cast 1-2 cells
10/22/59	Yellow	Turbid	7.5	1.017	2+	Neg.	Neg.	Occasional epithelial cell. 25-30 WBC Triple phosp. crystals
11/2/59	Yellow	Turbid	7.5	1.010	1+	Neg.	Neg.	Many RBC WBC

The cranial nerves are normal except that both of the pupils of the eyes are dilated and are not reacting to light.

The ophthalmoscopic inspection reveals bilateral papillitis and edema. The patient is unable to see the light thrown into each eye. The rest of the cranial nerves are negative. The spinal nerve reflexes show equal reflexes of all four extremities, and no pathologic reflexes are elicited. There is no astereognosis nor adiadochokinesia.

Impression: Bilateral optic disc papillitis, origin to be determined. Specific, inflammatory diabetes should first be considered. Intracranial or suprasellar tumor should be ruled out. There is a remote possibility of a pseudotumor.

An arteriogram was done on September 25, 1959.

After preliminary sedation with 4½ grains of Nembutal®, the patient was put on the x-ray table and his neck was prepared with alcohol and Merthiolate®. Subsequently a local of 1 per cent of procaine was used alongside the sternocleidomastoid muscle on the left side. With an 18 gauge needle in the left common carotid artery the blood flow was obtained from the internal carotid artery, and 10 cc. of Hypaque® was injected. Skull x-rays were taken in the anteroposterior position.

Preliminary inspection of this x-ray showed the dye in the internal carotid artery and its branches. Another 10 cc. of Hypaque was injected and x-rays of the skull were taken in both the AP and lateral positions.

The dye was present in the internal carotid artery and its branches. There was no particular displacement of the anterior nor middle cerebral arteries, and no intracranial aneurysm was visualized.

The patient withstood the procedure well.

Ultimate prognosis: This patient has been blind for seven days in his left eye and about two or three days in his right eye. The origin of his blindness is not clear to us at the moment. He does not seem to have anything wrong with his blood which would indicate that there may be an inflammatory or systemic disease.

The only findings are the slightly elevated protein in the cerebral spinal fluids along with a slight elevation in intraspinal pressure.

It is our opinion that this patient should have an exploratory craniotomy as soon as possible to rule out the possibility of a space-expanding lesion causing pressure on the optic chiasm. The sudden onset of the symptoms and lack of the additional findings indicating a disturbance of the pituitary gland would speak against the pituitary or suprasellar tumor, but an incipient tumor with hemorrhage in it, or a benign condition like a cyst could very well be responsible for the patient's blindness.

Craniotomy

An exploratory craniotomy was performed on September 25. The operative report follows.

Under Pentothol® anesthesia the patient was intubated by the anesthetist. A solution of urea

TABLE 2. Blood

Date					
9/24/59	Hb. 16.2	Hematocrit 46	WBC 5,000 Stab. 3 Seg. 62 Lymph. 35	Sugar 106 mg.	BUN 15 mg. V.D.R.L. Negative
10/1/59	Alk. Phosp. 13.6 units		Acid Phosph. 1.8 units		Prothrombin Time 15 seconds Control 13 seconds
10/3/59	Lee White = 7 min. 10 sec. Total protein 7.50 albumin 4.37 globulin 3.13		Platelets = 235,000		Calcium = 6.0 mg. Cholesterol 200 mg.
10/6/59	Na = 133 K = 3.5 Ca = 4.0 Phos. = 1.2		Febrile Agglutinins Typhoid pos. 1:320 Paratyphoid A = Neg. B = Neg. Brucella abortus = Neg. Proteus OX-19 = Neg.		C.R.P.A. Trace +
	RBC 3,230,000	Hb. 10.8	Hematocrit 31	Sed. R. 27	WBC 6,150 Stab. = 11 Seg. = 70 Lymph. = 16 Eosin. = 1 Atypical lymphs = 3
					LE = Neg.
10/9/59	C.R.P.A. = trace				

was started and a Foley catheter inserted.

The patient's head was shaved and he was placed on the operating table with his head supported by a cerebral head rest.

Towels wet with Zephiran® solution were used to drape the surgical area, and large sheets completed the draping.

After the scalp was prepared with soap and water and tincture of Merthiolate, an incision was outlined extending from the nasion in the midline, down to the posterior parietal area and then toward the left ear and slightly in front of it.

Raney clamps were used to the edges of the skin to control bleeding. The skin flaps was reflected forward and laterally together with the periosteum. Bleeding from the skin flaps was controlled with cautery and a towel was placed over them. The base of the flap was protected with a piece of 4 × 4 sponge.

The burr holes were made close to the midline and slightly above the nasion: one under the temporal muscle, close to the zygomatic process; one close to the ear under the temporal muscles; one in the posterior-frontal and mid-frontal areas.

The dura was adherent to the bone. This made it a little difficult to pass the Gigli saw in between the dura and the bone to connect the burr holes. The bone flap was lifted approximately one-half inch, and the remaining portion of the dura which was adherent to the bone was separated by means of a periosteum elevator. The bone flap was then broken over the temporal area and hinged on the temporal muscle. Bleeding points were controlled with cautery and bone wax, and then the reflected bone flap was secured in place with a towel.

The dura was inspected, and the bleeding points were controlled with cautery. The middle meningeal artery was coagulated and tied off with two black silk sutures.

There was a small laceration in the dura in the superior portion of the operative field. The dura was separated from the bone over the roof of the orbit and incised horizontally close to the sphenoid ridge and then longitudinally and parallel to the falx cerebri. The frontal lobe was protected with the flap and cottonoids, and then it was elevated upwards, close to the midline.

This procedure was done quite easily. The first cranial nerve was brought into view and divided by blunt dissection after coagulation of the vessels surrounding it. Then we proceeded with the frontal lobe elevation. The left optic nerve was brought into view together with the intercarotid artery. It was noted that there were some arachnoidal adhesions bonding the left optic nerve and the left internal carotid artery.

TABLE 3. Spinal Fluid

9/23/59	Pressure 240 mm. H_2O	Cells	Protein	Sugar	Chlorides
		None	49 mg. %	62 mg. %	134 mg. %
	Jugular compression 280 in 10 sec. Normal immediately after release of pressure.				
	V.D.R.L. Negative	Colloidal gold = 000 000 0000			
10/2/59	WBC = None	RBC/cu./mm. = 1444		Protein = 53 mg. %	
				Protein = 168 mg. %	
10/6/59	Turbid	WBC = 670	No organisms	No growth in culture	
		90% Poly.	or smear		
		10% Lymph.			
10/21/59	Protein 304 mg. %		No cells		

We continued with the separation and elevation of the frontal lobe down to the optic chiasm until the intercavernous sinus was brought into view and the chiasm visualized posteriorly to it. The pituitary gland was also visualized and appeared to be normal. The medial portion of the right optic nerve was also visualized and it also appeared normal. The left optic nerve had a normal color and it could, possibly, have been considered slightly swollen. There was no neoplastic tissue visualized in the vicinity. Palpation of the suprasellar region revealed no abnormalities. The whole area was inspected carefully several times to make sure that we were not missing anything, and we were finally satisfied that in the exposed area which was brought into view there was nothing which would be considered an expanding lesion.

The adhesions binding the left internal carotid artery and the optic nerve were carefully separated by blunt dissection. We made sure that hemostasis was completely controlled. The dura was closed with black silk sutures, and small strips of Gelfoam® were used at the edges of the bone to control the bleeding.

Small openings were made in the bone proper and in the bone flap, and a wire stitch was put through them. The bone was replaced and the wire stitches were tied off. Subsequently the stitches which were put in the dura were tied over the wire stitch bringing the dura against the bone with a small piece of Gelfoam placed between them to control bleeding. After the bone flap was secured in place, the skin flap was replaced and sutured in layers with black silk. The area was washed with saline and alcohol and Telfa dressing applied. The dressing was completed with Kerlex gauze. No drains were used.

The patient withstood the procedure well and was returned to his room in good condition.

This exploratory craniotomy revealed no expanding lesion which could be responsible for the patient's blindness. There is, of course, the possibility that there could be some lesion behind the stalk of the pituitary gland which cannot be brought into view.

Subsequently a laminectomy and decompression of dorsal vertebrae 1, 2, and 3 were done because the myelogram showed a complete block at dorsal disc 2, where there was a definite arachnoiditis. The arachnoid appeared thickened and white. It was opened over the extent of the laminectomy and adhesions were prominent.

The patient's recovery from both surgical procedures was relatively uneventful. There was no improvement in vision, and there was no return of either motor or sensory function to his lower extremities. During convalescence he developed a typical "cord" bladder.

Summary

This is a case of neuromyelitis optica. It is recorded because of the dramatic picture it presents and in the hope that it will stimulate someone somewhere to answer the question: What is neuromyelitis optica?

I wish to sincerely thank Dr. S. A. Dekowski, neurosurgeon, and Dr. W. DeYoung, internist, for their help in the diagnosis and treatment of this case.

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Rehabilitation

Of the Chronically Ill Aged

Edward E. Gordon, M.D.*, *Chicago*

The following cases are presented to exemplify problems demanding increasing attention, and to illustrate certain principles of action in their solution. These principles may be stated at the outset in a negative way.

A. Functional improvement following primary disease may be confounded by ensuing, but preventable deformities:

Case 1. A 67 year old woman was admitted from a nursing home to the hospital with intertrochanteric fracture of the left hip. X-ray revealed a successful fixation with evidence of healing across the fracture line. Contractures measuring 25° at the hip and 15° at the knee were present with functional shortening of the limb. Prolonged physical therapy failed to correct the deformities, and a stable gait was never achieved. She was discharged to a nursing home using a walker.

B. Though cerebral infarction is irreversible, adequate functional capacity may often be recalled.

Case 2. A 75 year old woman was admitted to the hospital with a right hemiplegia of two days' duration. *She was always conscious* and began to improve immediately. After three weeks she could lift her right heel off the bed while holding her knee straight. She began to ambulate within parallel bars, but the upper extremity remained useless. Three weeks later, discharge to a nursing home was planned. However, because of her desire to live in her apartment and continue a normal life, because her children were eager to help to maintain her there, and because of her good physical potential, she was returned home to continue treatment on an outpatient basis. In two months she achieved a great deal of independence: She walked with a cane and could use her left hand to eat and dress and do light housekeeping. The heavier chores were done by her children.

C. The diagnosis of senility may reflect the shortcomings of the labeler and not the labeled.

Case 3. A 65 year old woman entered the hospital from a nursing home with a diagnosis of senility and arteriosclerotic heart disease. She was slow, withdrawn, mentally dull, and inattentive. Her skin was pasty and dry and the eyelids puffy; she was sensitive to cold. The pulse rate was 66; basal metabolic rate minus 30; protein bound iodine 3.5 gamma. A diagnosis of myxedema was made. On small doses of thyroid her entire condition was transformed, and she became mentally and physically active. Her cardiac status never required treatment. She was discharged to the community.

These principles, it will be noted, are focused upon the hospital. This facility is vital in the chain of progressive management of the ill aged. Here treatment and rehabilitation can be readily applied in the early phase of illness and followed through with the most effective means of treating the patients' needs. Passing the responsibility from hospital to nursing home will continue to do injustice to many patients (see Case 2), to impose increasing financial burden upon families and health agencies alike, and to discredit medical practice in a field becoming ever more clamorous for attention. Therefore, the point of view adopted here is that rehabilitation for the ill aged should be started early in the hospital if maximal function is to be obtained.

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This is the ninth in a series of articles sponsored by the Committee on Aging.

TABLE 1. Change in Status of Independence in Locomotion from Admission to Discharge in 67 Patients

Admission		Discharge				
	Class	V	IV	III	II	I
Class	No.	2	12	13	19	21
I	0	-	-	-	-	-
II	7	-	-	-	-	7
III	10	-	-	-	3	7
IV	14	-	-	1	8	5
V	36	**2**	12	12	8	2

I. Completely independent outside home
II. Requires limited assistance outside home
III. Completely independent at home
IV. Requires assistance at home
V. Requires custodial care

Figures in bold face type denote number unchanged in status; others, improved.

TABLE 2. Change in Status of Independence in Self-care from Admission to Discharge in 67 Patients

Admission		Discharge				
	Class	V	IV	III	II	I
Class	No.	1	5	14	20	27
I	3	-	-	-	-	3
II	9	-	-	-	-	9
III	17	-	-	1	7	9
IV	26	-	2	7	11	6
V	12	1	3	6	2	-

I. Completely independent
II. Requires little help
III. Requires help in some activities
IV. Dependent on others for most activities
V. Completely dependent

Figures in bold face type denote number unchanged in status; others, improved.

A recent study highlights the effectiveness of rehabilitation on nursing home patients admitted to a hospital.[1] Incidentally, it became apparent that the majority of these had been transferred immediately from general hospitals to nursing homes as soon as the acute phase was comfortably over. Table 1 demonstrates improvement of motor functional capacity in 67 patients during rehabilitation training from admission to discharge. Of 36 (Class V, Locomotion) who required custodial care upon admission, 12 could walk with assistance; 12 walked independently indoors; 8, outdoors with some assistance; and 2 were completely on their own outside the home! Thirteen patients in Class IV on admission achieved Class I or II upon discharge. Ability to tend to personal needs in dressing, eating, toileting, followed the same pattern of improvement (Table 2). Of 26 patients largely dependent on others, (Class IV), 17 became independent or almost so (Classes I or II). Eight of 12 initial "custodial" patients could manage with some help (Classes II, III) at the end of their rehabilitative training. The number of patients in Classes IV and V dropped from 38 on admission to 6 on discharge. This demonstration proves a considerable gain in physical activity may be anticipated.

How did the mood change in the patients studied? One may expect that the sudden interest in their welfare (or plight, as seen from the patients' point of view) would inspire them with new hope in life. Many expressed this expectation when admitted to the program. Table 3 represents a progressive score of behavior similar to the motor assessment. Significantly, the number on Classes I and II swelled from 41 on admission to 92 upon discharge. Of 11 in Class V, 3 became tractable (Class II); of 28 in Class IV, upon discharge 21 moved up into the highest two classes. Thus, even the diagnosis of "senility" becomes uncomfortably suspect. This situation was dramatically seen in Case 3.

Dollar statistics derived from this pilot geriatric program also proved heartening. After an average of 16 months' follow-up, 91 out of 111 patients were discharged mainly to boarding homes and some to homes of relatives. This disposition resulted in a saving of over $110,000 for Cook County Department of Public Aid: It was cheaper to board a patient in the community than to maintain him in a nursing home. Supposing some means were at hand to rehabilitate patients immediately after the acute stage and then place them in the community, what would the ultimate savings be? This is a worthwhile question to consider.

[1]*The program was conceived by the Illinois Public Aid Commission and carried out by the Cook County Department of Welfare with the joint cooperation of Michael Reese Hospital and Medical Center and Rest Haven Rehabilitation Hospital. It was subsidized by the Illinois Public Aid Commission and the United States Public Health Service, Research Grant RG-6137 C2.*

TABLE 3. Estimate of Change in Social Behavior from Admission to Discharge in 111 Patients

Admission		Discharge				
	Class	V	IV	III	II	I
Class	No.	6	5	8	45	47
I	8	-	-	-	-	**8**
II	33	-	-	-	**9**	24
III	31	-	-	**4**	14	13
IV	28	-	**3**	4	19	2
V	11	**6**	2	-	3	-

I. Makes good adjustment to hospital and illness
II. Occasionally confused or disoriented but takes initiative with daily needs
III. Passive and apathetic without initiative
IV. Delusional, disoriented, severely depressed or confused
V. Overtly psychotic

Figures in bold face type denote number unchanged in status; others, improved.

In the light of the findings of this study, one may well ask why patients are sent to nursing homes from general hospitals without benefit of further restorative care. It is not because they lack potential, nor is it cheaper. The answer, I believe, is that our health institutions are not yet adapted to today's medical problems. Excellent when it comes to treating the surgical or medical episode, they are not organized to treat disability consequent to an acute event, or chronic disease requiring a period of active convalescence (not passive convalescence, such as the average nursing home gives). In general, hospitals lack continuous facilities for patients needing progressive mobilization of mind and body in inverse proportion to the need for nursing care. Furthermore, there is a general lack of knowledge among medical student, house staff, nurse, and physician as to the techniques and usefulness of rehabilitation in all its phases. Beginnings have been made at Bellevue Hospital in New York and other hospitals scattered through the country where progressive restorative medicine is practiced. Large savings would accrue to county and other municipal hospitals if departments of physical medicine and rehabilitation were installed in them.

But what of the smaller hospitals and smaller communities? What of any general hospital where full scale, long term rehabilitation facilities are not possible as yet? The following progressive plan is focused upon the acute and early convalescing stages of illness. The appropriate rationale is stressed for three common motor disorders seen in the chronically ill aged. The hands to carry out the plan are recruited from those found at the scene.

Cerebral Infarction—Hemiplegia

1. Since secondary disability due to contractures often penalize the hemiplegic patient, prevent them by proper positioning upon admission. Elevate the arm and hand to avoid edema and ultimate stiffness. Prevent equinus, knee flexion, and hip external rotation contractures and loss of joint mobility of the upper extremity by well-known principles of physiologic positioning.[1]

2. Start passive motion of the paralyzed limbs early. When a patient can lift the heel one inch off the bed, he is ready for gait training, provided his general condition permits. The patient begins in parallel bars, then graduates to a cane. A short-leg brace may be required; less often a long-leg brace. It is known that 80 to 85 per cent will walk with or without aids. Train the good upper limb to serve for both, if necessary, and don't forget speech therapy for aphasia.

3. A previously active life, preservation of intellectual function, and the will to regain independence (see Case 3) are positive factors. Aphasia of the expressive (motor) type is not to be confused with poor intellectual capacity. As long as a patient can respond to simple requests and retain what he has learned, he should be trained at least in the areas of ambulation and self-care.

Arteriosclerotic Peripheral Vascular Disease—Amputation

1. Seriously consider a below-knee amputation in favor of above-knee.

2. Start early shrinkage of the stump with elastic bandages, along with strengthening of muscles and mobilization of joints, both in the sound and amputated limb. (The hip abductors of the stump are excepted from strengthening).

3. Prevent secondary deformities by positioning: abduction, flexion, and external rotation of the thigh in the above-knee amputation; and these along with flexion contracture of the knee

[1] *Well illustrated guides for these and the following procedures are available, e.g., "Strike Back at Stroke." Obtainable from Superintendent of Documents, U.S. Printing Office, Washington* 25, *D.C.*

in a below-knee amputation. Allow no pillows under the amputated stump. The patient should lie face down several hours daily to prevent flexion contractures of the proximal joint or joints.

4. Start early ambulation first in parallel bars, pick-up walker, and finally crutches, pending delivery of the artificial limb. A remaining limb can thus be given a therapeutic trial. Order an artificial limb only when shrinkage is almost complete.

Fractured Hip—Pre-healed Stage

From 33 to 50 per cent of elderly people ultimately become dependent on others. The common reason is poor postoperative management of residual function.

1. It is important to prevent secondary deformities by proper positioning. This includes external rotation of the hip, hip and knee flexion contractures, and equinus deformity. Forbid a pillow under the knee, and allow free motion of the foot.

2. Carry out early passive motion to preserve function. Abduction and external rotation are the last to be achieved, but gentle flexion may be carried out even 48 hours after pinning of a surgical neck. Each case must be individualized.

3. Maintain conditioning by active exercises of the sound limbs and later of the involved one. This program will quickly refit a patient to walk without weight-bearing in paralleled bars, crutches or pick-up walker. Naturally, cardiovascular and other systemic diseases will have to be reckoned with.

An important universal precaution is to avoid binding the feet in plantar flexion with bed linens tucked tightly under the foot of the mattress. The use of bed span removes this objection.

The points discussed above require special personnel. Where physical and occupational therapies are available in a hospital, the solution is at hand. Where they are not, the principles can be carried out by house staff and particularly nurses under the supervision of the attending physician. Heartening solutions along these lines are beginning to appear. One is the "Continuation Care Unit," where chronic illness and disability are managed by nurses whose responsibility is to improve ability in activities of daily living, without "complicated procedures of rehabilition."[1] From the experience, moreover, with the rehabilitation study previously mentioned, it is my opinion that an interested and sympathetic nurse conversant with the simple techniques of rehabilitation can manage the bulk of the disabled in the older age group. This concept may stimulate a new field of service and satisfaction to the nursing profession. Hospitals without physical and occupational therapists can send a selected nurse to one of the many courses in rehabilitation nursing offered in this country. The hospital can thus provide early, preventive rehabilitation, and in the stage immediately following, some degree of training in self-care.

If such a plan be adopted utilizing a "rehabilitation nurse," patients need not be referred without preparation to nursing homes where rehabilitation has barely permeated.

Hopefully, some patients may go home when they convince relatives that they are not so helpless as during early days of illness.

For many patients the nursing homes would represent the next stopping place. Yet, if the latter can be brought into the orbit of rehabilitation, continuing care may be achieved. An excellent start has already been made through the "Rehabilitation Education Services" sponsored by the Illinois Public Aid Commission and directed by Dr. H. Worley Kendall and Mr. J. A. Hackley of Peoria. Teams travel the circuit of nursing homes to instruct the personnel in the basic concepts of rehabilitation. To supplement this process, a means for finding community living facilities will be required because some of the patients will become independent.

Analagous in purpose to the nursing home are the outpatient clinic and home care program. The former facility needs no more discussion here beyond referring again to Case 2. Home care programs are well-known, but few are geared to the mission of rehabilitation in the home. Management should be focused upon comprehensive medicine and not merely prescription of medicines. This is not the place to give detailed blueprints for such an auxiliary service. Each community, each rural or urban area will have to solve its problem in its own way, according to available facilities, traditions, and strength of community resources and spirit.

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[1] *Lockward, H. J., Thomas, E. J.: Progressive Patient Care, J.A.M.A.* 172: 132-137 (*Jan.* 9) 1960.

Today, concern with acute illness is not enough. Continuing care by restorative medicine is essential for sound treatment. In the plea for early action is the familiar one of preventive medicine. Into this continuity of effort the family or the friend must also be drawn. Properly conceived, rehabilitation of the disabled or chronically ill patient extends into his biological, psychological, and social levels. Most often profound therapy is unnecessary, if the person's needs are anticipated and fulfilled as far as possible.

Summary

1. Many elderly disabled patients have potential which may be exploited by preventing secondary physical deformity, tapping personality strengths and residual capacities, and utilizing environmental and family assets.

2. In a pilot treatment program based on the above practices, 91 of 112 patients were so improved they left nursing homes for community living. The community saved $110,000 as a result. Had these individuals enjoyed restorative medicine during the prior hospital stay, more savings in human suffering and resources would have accrued.

3. Rehabilitation of the ill aged may be regarded as starting in the hospital with the application of simple principles by physician, nurse, and other trained personnel. Allied to this effort should be the nursing homes, the home care service, and the outpatient clinic.

Primary pulmonary hypertension

The pathogenesis of primary pulmonary hypertension is still unknown. It may be due to persistence of the fetal anatomy of the pulmonary vessels, excessive pulmonary vasomotor tone, or other unknown factors. Neuro-hormonal imbalance may produce increased pulmonary vasoconstriction, or repeated thrombo-embolic episodes may occur, causing obstructive lesions in the pulmonary arteries. The possible role of serotonin in this disease has recently been considered.

Howarth and Lowe showed that exercise can increase the pulmonary vascular resistance and, thereby, further reduce the already critically low cardiac output with a resultant fall in systemic blood pressure, syncope, and, in some cases, sudden death. Hypoxia has been demonstrated in the pulmonary artery just before a syncopal attack. This may be one factor causing the increase in pulmonary vascular resistance. Sudden deaths have occurred during or shortly after cardiac catheterization and induction of anesthesia and following simple vena puncture. Two deaths were reported in association with the administration of barbiturates. Sven Rune Johnson, in 1951, reported a striking drop in cardiac output and a slight increase in peripheral resistance with barbiturate anethesia. P. Winchel also reported a decrease in cardiac output and an increase in peripheral resistance after the administration of sodium amytal in normal patients. It has been recommended, therefore, that barbiturate or general anesthesia be avoided in such patients in favor of local or spinal anesthesia. In view of the foregoing factors, any investigatory or surgical procedure may be hazardous in such a patient. *Katherine H. Borkovich, M.D. Primary Pulmonary Hypertension. Maryland M. J. January 1961.*

Tuberculosis in Children

A Symposium — Part I

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Why Should the Physician Perform A Tuberculin Test?

WILLIAM R. BARCLAY, M.D.

The principal reason for performing a tuberculin test is to determine whether a child has been infected with tubercle bacilli. The test is used for the following reasons:

a. Tuberculosis is generally either asymptomatic or the symptoms are nonspecific and frequently confused with those of a mild upper respiratory tract infection.
b. Physical signs are usually lacking even when the disease is far advanced. In fact, a reliable diagnostic point is the discrepancy between physical findings and the extent of x-ray findings in the case of pulmonary tuberculosis.
c. In children, tuberculosis may exist in organs other than the lungs—for example, renal, bone and joint tuberculosis—with no x-ray findings in the chest.
d. The only absolute diagnostic test for tuberculosis indicates tubercle bacilli in the sputum. It is difficult and time-consuming and in the interest of diagnostic efficiency should be performed only when the skin test is positive.

A tuberculin test should also be used to locate sources of active tuberculous infection.

a. Children are very sensitive and specific indicators of foci of tuberculous infection in their environments. The younger the child and the more limited his contacts the more specific a localizer he is. If one finds a tuberculin-positive child of pre-school age, an intensive search should be made in the immediate family for the source of infection.
b. It is more economical to skin test groups of children and then x-ray the parents for positive reactors than to do mass x-ray surveys in a community. However, it is worth making the point at this time that school children should not be used as a captive test group for community health surveys. Primary goals are to protect the children against the complications of tuberculosis, and only a secondary gain is the information that permits selective community case-finding surveys.

The value of the test depends, of course, on two factors, its sensitivity and its specificity. With proper technique it is possible to detect 98 per cent or more of all infected individuals. False negative tests do occur. These are found in persons with far-advanced terminal tuberculosis and with sarcoidosis and Hodgkin's disease, occasionally in persons suffering from virus diseases such as measles, and occasionally in persons receiving large doses of steroids. The test is specific for infection by mycobacteria.

Presented before Chicago Pediatric Society, Feb. 21, 1961.

However, these are ubiquitous, and there are many strains of mycobacteria that are of low virulence, or completely saprophytic. Infection with one of the atypical strains may give rise to a weakly-positive tuberculin test when the tuberculin used is manufactured from a human strain of bacilli. These reactions, however, fall below the criteria for reading a typically positive reaction, as shall be discussed later.

The greatest value can be obtained from tuberculin testing only if a standardized preparation and technique are used. It might be well at this point to discuss some of the history of the test.

The first material used was old tuberculin, as described by Koch, prepared in 1890 by evaporating, heating and filtering, and phenol-treating the media in which human bacilli had been grown. This material is still in common use and is called OT. Because other protein substances, in addition to those used by the tubercle bacilli, are present in this preparation, Sebert and Long described a method for making what is now called purified protein derivative (PPD). The tubercle bacilli are grown on synthetic media that contain no added protein. The protein they produce is not only concentrated and filtered to remove living bacilli but is precipitated by half saturated ammonium sulfate and then reconstituted. PPD is now generally accepted as having advantages over OT.

In addition to variations in the technique of preparing the test material, there have been many variations in the technique of administration. Von Pirquet introduced the antigen into the skin by a small scratch. His method has the disadvantage of introducing an unknown amount of antigen into the skin. Vollmer cleansed the skin with an organic solvent and applied the antigen in the form of a patch attached to adhesive tape. This is a method widely used by pediatricians; it is painless and easy to apply, and the testing material can be conveniently stored. This is generally regarded as an unreliable method and is discouraged in clinical and field-testing programs. The method widely used by veterinarians but not by physicians is dripping the antigen into the conjunctival sac. The Mantoux test, an intracutaneous injection of 0.1 ml. of antigen into the epidermal layers of the skin is the most widely used method. If Old Tuberculin is used, one may start with a concentration of 1:10,000 (.01 mg. of OT) although some prefer to use 1:1,000 (.1 mg. of OT).

If PPD is used, one may employ what is known as first strength PPD or one tuberculin unit representing .00002 mg. of protein. With the lower concentrations of both Old Tuberculin and PPD antigen, there is a significant number of false negative reactors. Therefore, the concentration of antigen widely recommended is that termed intermediate PPD or 5 tuberculin units (0.0001 mg. of PPD). This is a concentration recommended by Palmer and generally used by the United States Public Health Service and the World Health Organization in mass testing programs. If one uses a test of 5 tuberculin units of PPD, a positive test is interpreted as an area of induration 5 mm. or larger present at 48 to 72 hours.

One might say a word here about the stability of the testing antigen. In concentrated solution Old Tuberculin is stable for longer periods of time. However, once it is diluted to 1:10,000 or 1:1,000, and especially if it is stored in only partially filled glass bottles, the potency of the material degenerates, and one cannot accurately interpret the tests. Fresh preparations are made each time the antigen is to be used. PPD in the dry state is stable indefinitely. If reconstituted, it can be used for as long as two weeks; one need not follow literally the package information that recommends that once in solution, the antigen must be used immediately or discarded.

Finally, we might ask the question, what is the significance of a positive tuberculin Mantoux test. First of all, it means that the positive individual probably has living tubercle bacilli within his body. This, of course, does not mean that he has active clinical disease. However, in the child five years and under it is probably wise to consider that a positive tuberculin test is equivalent to active clinical disease. Recent conversion should also be considered as representing active disease regardless of whether or not there are positive findings on x-ray and gastric washing examinations. Secondly, one cannot correlate in any single individual the size of the tuberculin reaction with the probability of the disease being clinically active. However, in groups of children, those with the largest tuberculin reaction subsequently have the highest incidence of active clinical disease. Therefore, from a practical standpoint, one would

be more apprehensive about a young child with a large reaction than a young child with a questionable or minimal positive reaction.

In summary, therefore, we can say that the tuberculin reaction is a highly specific, highly sensitive method of detecting children who are harboring living tubercle bacilli, and a method of localizing persons who are spreading disease within the community. The test is most valuable when 5 tuberculin units of PPD intracutaneously is used. The antigen is highly standardized and generally used not only in this country, but throughout the world. It is reasonably cheap and stable; giving the test is easy and should be a routine procedure used by nearly all physicians in private clinical practice. Whether or not one should use a positive tuberculin test as a basis for treatment of the child in question will be the subject of Dr. Lichtenstein's paper.

Prophylaxis of Tuberculosis in Children

M. R. Lichtenstein, M.D.

What can be done about the prevention of tuberculosis in children? Both private practitioners and public health officials have a renewed interest in prevention through use of isoniazid or BCG vaccine in appropriate groups. This paper is intended to present some of these considerations.

General precautions

The tuberculous adult is the main source of danger to children in contact with him. Therefore, the most important protection for children lies in the detection, isolation, and treatment of these adults. Every physician should report his tuberculosis cases and suspects to the department of health so that all contacts can be examined. Furthermore, every physician should give tuberculin tests at least annually to children under his care. When the test becomes positive, the child has been infected and requires x-rays for supervision and possibly isoniazid.

First infection with tubercle bacilli causes a primary lesion. This may be microscopic or may advance to show demonstrable enlargement of lymph nodes in the chest with or without infiltration of pulmonary tissue. The primary lesions themselves cause little or no clinical illness, and about 95 per cent heal in 6 to 24 months even if untreated. Living bacilli may persist for years in the so-called "healed" lesions.

The term *prophylaxis* is used with two different meanings: (1) to prevent infection with tubercle bacilli (primary prophylaxis), and (2), to prevent the serious complications of tuberculosis among children already infected, i.e., tuberculin-positive. The latter is called "secondary prophylaxis" by some, and "treatment" by others. The serious complications of infection such as tuberculous meningitis, miliary tuberculosis, and destructive pulmonary lesions are the most important manifestations we try to prevent.

The risk of serious complications

The United States Public Health Service in a recent study[1] reported that one out of 11 tuberculin-positive children under one year of age developed extrapulmonary complications if no treatment was given. Between ages one and four, one in 26 untreated infected children developed such complications. Infected children constitute only a small percentage of the child population. The study also states that children between one and six years old and those over six were at little risk unless they had positive x-ray findings. The greatest risk of serious disease, therefore, exists during infancy; the least risk occurs from four years to puberty, and a greater risk during adolescence. Furthermore, the risk of complications is greatest during the first two years following initial infection (conversion of tuberculin reaction to positive). Thereafter the primary infection is almost always well healed, and complications rarely occur unless the child is re-exposed by contact to a sputum-positive case.

Isoniazid prophylaxis

It is apparent that the following groups of children should receive isoniazid prophylaxis:

1. All children under one year of age with positive tuberculin reaction. (They are recent contacts.)
2. Children one to four years old with positive tuberculin reaction, especially if there is x-ray evidence of large glands or parenchymal infiltration.
3. Children whose tuberculin test has converted to positive within the previous year.
4. Children with positive tuberculin test found in contact with an adult who has active tuberculosis.
5. Tuberculin-positive children receiving steroids.
6. Possibly tuberculin-positive diabetic children.
7. Tuberculin-positive children with an acute contagious disease.

Because children with large reactions (over 15 mm.) to tuberculin may be at greater risk, there have been proposals to treat them also.

Isoniazid, 5 to 10 mg. per kilogram daily for one year, divided into two or three doses per day, will prevent about 80 per cent of the serious complications in tuberculin-positive children. It suppresses multiplication of tubercle bacilli and, therefore, has no effect on dormant bacilli in healed lesions. Toxic effects in children are very rare. The drug is valuable only if given at the appropriate time, and has no further effect when stopped.

The use of isoniazid as a prophylactic agent should be weighed in the case of each child. Factors favoring its use should be any of these: nonwhite, low economic status, malnutrition, poor health due to other disease, age under four, age over puberty, and a history of tuberculosis in the family. Factors which speak against the need of isoniazid are the following: white, no clinical or x-ray evidence of tuberculous or other disease, age four to twelve years, knowledge that the primary lesion has been healed for two or more years, and no family history of tuberculosis.

BCG vaccination

Prevention in Tuberculin-Negative Children. Among the recent Arden House recommendations[2], "The Conference recommended use of BCG according to the recommendations made by the Ad Hoc Advisory Committee on BCG to the Surgeon General of the U. S. Public Health Service, and by the American Trudeau Society." This refers to "children living in areas with a high prevalence of tuberculosis," usually city slum areas. Double-blind studies of BCG vaccination in England[3] showed "a reduction attributable to vaccination of 83%," and "similar high levels of protection have continued up to at least six and one-half years after entry." Authorities agree that mass BCG vaccination of children is not required in this country. It is evident, however, that a considerable reduction of the disease among children in the high prevalence areas could be obtained by use of BCG vaccination. BCG, therefore, has relatively little application in the private practice of physicians, but may have great and useful application in the public health services of communities that have slum areas. The evidence indicates clearly that BCG will prevent almost all cases of tuberculous meningitis and miliary tuberculosis among children. It has the special value of giving protection to large groups who may not remain under close medical supervision.

A special problem arises in those tuberculin-negative children recently exposed to an active case of tuberculosis. The child may have been infected but has not yet converted to positive. He should, of course, be separated from the source case, and may then be managed in several ways. (1) The tuberculin test should be repeated at six or eight week intervals. If it remains negative, the child has not been infected. (2) If the tuberculin test turns positive, isoniazid prophylaxis should be considered. (3) If the tuberculin test remains negative after two months, BCG vaccination may be given if the child is in danger of re-exposure, or if the parents are likely to be uncooperative.

Prophylaxis of children in Chicago

In Chicago, as in all other large cities, there still is considerable tuberculosis confined largely to people living in the lower economic areas of the city. The case and death rates among nonwhites is two and one-half times that among whites.

For the past three and one-half years the Municipal Tuberculosis Sanitarium has used isoniazed prophylaxis for children found in contact with an active case of tuberculosis and for convertors. One disadvantage of this program has been that parents are not cooperative in carrying out treatment. On the average, only about

50 per cent of the children finish the one year of isoniazid therapy required. In the higher economic areas of the city, about 75 per cent finish the course of treatment, while in the lowest economic areas, only 40 per cent finish therapy. This lack of cooperation is similar to that observed in prophylactic efforts against poliomyelitis and malaria, and points up the value of a vaccination that can be given at one visit.

Rosenthal[7] has used BCG vaccination for suitable groups of children in Chicago for the past 25 years. He found an 80 per cent reduction in tuberculosis among the vaccinated. This has been corroborated by the studies in England[3], in Sweden[4], and among American Indians[5]. Each year at Cook County Hospital BCG is given to about 4,000 newborns, mainly nonwhite, from the lower economic groups. BCG is also given to negative reactors recently in contact with active tuberculosis and to children born of tuberculous mothers. Several other hospitals also are using BCG for appropriate groups of children.

In 1952, 58 children under the age of five died of tuberculosis in Chicago. The number fell to 8 in 1960. The main cause for improvement probably was less exposure of small children because of better isolation of active cases among adults, and greater numbers of patients under chemotherapy. However, the use of BCG and isoniazid for children undoubtedly contributed toward this result.

Anti-tuberculosis programs among children require repeated tuberculin testing of negative reactors and chest x-rays of positive reactors at appropriate intervals. In Chicago, it has not been possible to carry out annual tuberculin testing of all children because of the vast number (about 750,000) of children. The Tuberculosis Institute has been able to spot-check various schools at irregular intervals for many years, and has found evidence of a marked decline in the infectivity rates. However, some high schools in high prevalence areas of the city have 25 to 35 per cent positive reactors, indicating that many children are still exposed. These contribute to the large number of cases of serious clinical tuberculosis between ages 15 and 25 years (Table 1). A program of BCG vaccination of adolescents in the high prevalence areas would help greatly in controlling disease in this age group.

TABLE 1
CHICAGO — TUBERCULOSIS IN CHILDREN

Deaths Age 0-4 years	Active Cases Age 0-4	5-14	15-24
1952 — 58	160	92	434
1956 — 20	53	67	355
1957 — 9	49	52	343
1958 — 6	36	40	314
1959 — 6	39	46	282
1960 — 8	40	37	274

Conclusion

Certain groups of children can be protected against the serious complications of tuberculosis infection. The use of isoniazid for positive reactors and BCG for negative reactors has been outlined. In spite of declining tuberculosis rates, there is an important place for the preventive measures available, particularly among underprivileged groups and among individuals at special risk.

(To be concluded)

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Maxims are to the intellect what laws are to actions: They do not enlighten, but guide and direct, and though themselves blind, are proctecting. — Joubert

Contributions of Electron Microscopy To Lipid Physiology and Atherosclerosis

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One of the basic assumptions of medicine in general and pathology in particular is that alterations in the intracellular mechanisms form the basis of disease processes. The electron microscope, with its power to resolve structures of molecular dimension, has become one of our most useful tools in the study of cellular structure in normal and pathologic tissues. Both the assumption and the tool have been applied to the study of the metabolism of lipids and atherosclerosis. These inquiries have been concerned with the local arterial lesion as well as the structural factors concerned in lipoid physiology. In both areas the electron microscope has been used in conjunction with light microscopy and histochemistry.

Pinocytosis

Basic to a consideration of cellular pathology is a knowledge of the mechanisms by which material is taken into and transported through the cell. One of these processes is pinocytosis, and it has received considerable attention from electron microscopists. This process can first be seen as an invagination of the outer, or plasma, membrane of the cell into which are sequestered various materials from the extracellular milieu. The invaginated portion increases in size and eventually becomes pinched off from the cell surface. At this point a spherical, membrane-bound body, which contains the substances originally present extracellularly, lies completely within the cytoplasm of the cell. This minute vesicle then moves through the cytoplasm to discharge its contents at a point on the cell membrane remote from the initial invagination.

Pinocytosis has been implicated in both of the problems which concern us here. This mechanism has been observed as one of the earliest morphologic expressions of the endothelial cell in developing atheromata.[1] It also has been described in the transport of lipids across the intestinal epithelial cell, a process basic to lipoid physiology.

The endothelial cell

Our knowledge of the fine structure of atheromatous formation is due largely to the work of Buck[2] and Parker.[1] On the basis of their papers it is possible to reconstruct the early changes in arterial walls during the experimental production of atheromata. The endothelial cells lining vascular walls normally present a continuously varying contour. During hypercholesteremia aggregates of lipid collect on the surface of the variegated plasma membrane. The lipid in these small deposits is then taken into the cells by pinocytosis. Whether the ingested fat exists as a lipoprotein or in some other form is not known. The lipid is then moved across the cell and is deposited in the subendothelial space. Here at least two mechanisms have been described. The fat may be taken up by cells in this space, or it may enter the fibrils of the internal elastic lamina. The latter process is thought by Parker[1] to produce molecular alteration in the lamina. This is considered to be the initial injury to a structure which has long been considered a barrier to the passage of lipid into the media. Perhaps the most significant observation by Parker was the evidence of deposition of lipid on the vascular endothelial cells within 24 hours of the onset of acute lipemia.

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While the Nutrition Committee of the Chicago Heart Association is sponsoring this article, the opinions expressed are those of the author and do not necessarily represent the official view of the committee.

These findings are of especial interest in that they provide support for two long-standing hypotheses on the pathogenesis of atherosclerosis. These are the imbibition and encrustation hypotheses. Until recently these two explanations have been considered mutually exclusive. On the basis of the electron microscopic data now available, however, it appears that both processes are involved. Encrustation of lipids occurs on the endothelium, in the presence of lipemia, and imbibition of the lipid proceeds by pinocytosis. Whether this combined encrustation-imbibition hypothesis will survive the arrival of newer data remains to be seen.

Parker's concept of molecular alteration in the internal elastic lamina caused by infiltrating lipid is provocative and deserving of vigorous exploration. Not only is his suggestion of importance in the study of atherosclerosis but the implications for pathology in general are clear.

Intestinal epithelial cells

The transport of lipid across the intestinal epithelium has long intrigued cytologists, physiologists, and biochemists. This process is of obvious importance in the delineation of the events in lipid metabolism. It assumes even more interest as evidence accumulates that the intestinal absorption of fat may be abnormal in patients with atherosclerosis.

Some of the earliest work with the electron microscope was directed to an examination of the fine structure of the intestinal epithelial cell. The brush border of these cells, long a subject of controversy, was found to consist of thin, fingerlike projections, now known as "microvilli." These structures increase by 20 to 30 times the surface area presented to the luminal contents. Other cytoplasmic organelles such as the Golgi apparatus and endoplasmic reticulum have been described in detail. The pathway of fat through these cells has been studied by Palay and Karlin.[3] They demonstrated pinocytotic activity at the base of the microvilli with passage of lipid from the luminal surface of the cell into the cytoplasm. It then enters a series of canals within the cytoplasm, the so-called endoplasmic reticulum. The fat then passes out of the cell into the lamina propria and finally into the lacteals. Thomas and O'Neal[4] have shown that absorbed butter and corn oil differ appreciably in their electron microscopic appearance in the intestinal epithelial cells. They pointed out that diets high in butter produce vascular lesions in experimental animals while those containing corn oil do not. Whether the variable appearance of these two fats is due to the degree of unsaturation is conjectural.

Future studies

Considerably more information may be expected from electron microscopic observations in these two areas in the future. Perhaps the most fruitful efforts will develop from an alliance between fine structure morphology and biochemistry. Obviously, membrane kinetics are of extreme importance in the processes discussed here. Pinocytosis is a convenient morphologic concept, but little is known of the energetics involved, the rate-limiting reactions associated with the mechanism, or the interactions of vesicular contents, membrane and cytoplasm.

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Four elements of sobriety

Based on observations of Alcoholics Anonymous as its program has affected change in many members, and from clinical experience with alcoholic patients, a hypothesis is formulated concerning the effective psychological events which make possible the maintenance of sobriety. Four elements are recognized as playing an essential role: hitting bottom, surrender, ego reduction and maintenance of humility. The application of this conceptualization in individual psychotherapy is discussed and illustrated with case material. *Harry M. Tiebout, M.D. Alcoholics Anonymous—An Experiment of Nature. Quart. J. Stud. Alcohol. March 1961.*



Pyloric Obstruction

Moderator:
Robert J. Freeark, M.D.
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Discussants:
John Van Prohaska, M.D.
Professor of Surgery, University of Chicago Medical School

William Meszaros, M.D.
Director, Department of Diagnostic Radiology, Cook County Hospital; Associate in Radiology, Northwestern University Medical School

Dr. Robert J. Freeark: Throughout the entire gastrointestinal canal, obstruction is usually a surgical problem. Most such obstructions, however, demand an equally important period of preoperative treatment in an attempt to reverse the severe metabolic insult which they impose. This is particularly true of obstructions of the stomach, which, regardless of cause, are usually insidious in onset and devastating in their effects upon the body economy. Many days may be required to reverse these effects before the patient is operable.

Pyloric obstruction is a disease process in which the patient suffers from starvation and the peculiar effects resulting from vomiting of electrolytes normally secreted by the stomach and reabsorbed by the small intestine. The involved stomach is frequently hypertrophied, edematous, and so engorged with blood that it is unsatisfactory from the standpoint of operative treatment. There are few problems in all of surgery which require the intensive and painstaking efforts that go into the successful diagnosis and treatment of pyloric obstruction.

Our guest this morning is exceptionally well qualified to help us. Dr. John Van Prohaska is professor of surgery at the University of Chicago Medical School. He has combined the many years of a very busy private surgical practice with a distinguished academic career at the University of Chicago. His interest in and contributions to gastric physiology and surgery are a matter of record, and his familiarity with the many facets of this problem will, I am sure, become quickly apparent. We are most happy to have him with us, and we will proceed now with the presentation of cases.

Case 1

Dr. John Boswick, surgical resident: This 63 year old white female was admitted to Cook County Hospital with a seven month history of nausea and right upper quadrant pain following meals. She denied having previous gastrointestinal difficulties before these. She stated that the pain was made worse by eating and was relieved at times by vomiting. The vomitus was occasionally bile-stained and usually contained food recently ingested, but it had never contained blood or coffee-ground material. Although the patient was aware of a 50 lb. weight loss in the 7 months of her illness, she had never sought or received medical attention prior to admission.

Physical examination revealed an emaciated

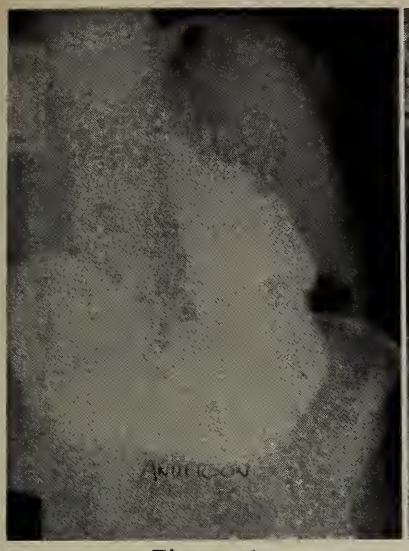


Figure 1

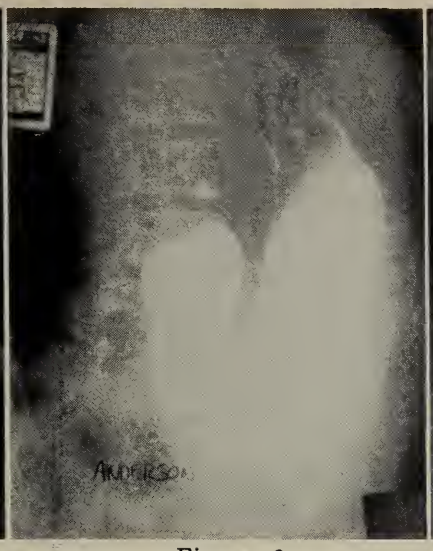


Figure 2



Figure 3

Radiologic study of stomach. Case 1. Figure 1 shows marked dilation. Figure 2. Marked retention of barium after one hour. Figure 3. Over 50 per cent retention of barium 24 hours after ingestion.

and dehydrated elderly female with marked upper abdominal distention. There was evidence of weight loss and mild anemia. The significant physical findings were limited to the abdomen, which was distended by a large boggy mass that descended to the level of the pubic symphysis. The swelling was not tender and, on manipulation, a succusion splash was readily elicited. There were no palpable abdominal masses or evidence of organ enlargement. Pelvic and rectal examinations were negative except for a 1+ stool benzidine.

Laboratory study disclosed a white blood cell count of 8,000, hemoglobin 68 per cent, red blood cells 4,500,000. Blood chemistry showed nonprotein nitrogen 70 mg./100 ml., total protein 6.0 Gm./100 ml., sodium 136 mEq./L., chlorides 76 mEq./L., carbon dioxide combining power 75 vol. % and potassium 2.4 mEq./L. Radiologic study revealed a markedly dilated stomach with more than 50 per cent retention 24 hours following ingestion of barium.

After the diagnosis of pyloric obstruction was established, attempts were made to evacuate the distended stomach with an Ewald tube and continuous nasogastric suction through a Levine tube. In addition to considerable amounts of barium, the Ewald tube returned undigested vegetable particles, including carrots and string beans the patient denied having eaten in the past month. Appropriate electrolyte replacement solutions were given intravenously. A gastric analysis was carried out, and on histamine stimulation 32 units of free acid were obtained. After restoration of fluid and electrolyte balance and continuous decompression of the stomach, laparotomy was performed.

Dr. Freeark: Before we begin the discussion of this case we will review the x-rays.

Dr. William Meszaros: On this first film the stomach is markedly dilated (Fig. 1). There is poor peristalsis in the stomach and only a fleck of duodenal bulb is seen, but we can see most of the stomach. Therefore, we would think this is duodenal ulcer with secondary obstruction. At one hour (Fig. 2) there is marked retention, but we can see the entire stomach. At 6 hours the stomach is still distended with barium; perhaps 1 per cent of barium has passed through. Marked 6 hour retention can occasionally be due to spasm but is organic until proven otherwise. At 24 hours (Fig. 3) there is retention, and we can see a duodenal ulcer crater.

The radiologic diagnosis is duodenal ulcer with marked pyloric obstruction.

Dr. Freeark: A stomach of this size, descending to the level of the pubic symphysis, has rightly been called a "pelvic stomach." This patient has been working on her obstruction for about 7 months and has lost 50 lbs. in weight. Her prior medical history is unimpressive. Such an advanced degree of obstruction is uncommon today because patients usually seek treatment earlier; but we still occasionally see them, and

they often represent both a diagnostic and therapeutic problem. Dr. Prohaska, can you tell us how you would approach the diagnosis and therapy of such a patient?

Dr. John Van Prohaska: This is a beautiful example of pyloric obstruction. If you note the laboratory reports of nonprotein nitrogen 70, chloride 76 mEq./L., potassium 2.4 mEq./L. and a carbon dioxide combining power 75 vol. %, you could not have a more classical case of alkalosis due to loss of chloride and other electrolytes by vomiting or suction. The magnitude of these losses will be even more apparent when dehydration is corrected. We must correct this alkalosis, overcome dehydration, arrest the starvation, and cure the cause of her obstruction. The task is not an easy one.

Such an obstruction is usually due to one of two causes, peptic ulcer or gastric cancer. The x-rays show a stomach that is markedly dilated. Hypertrophy has undoubtedly occurred, and this is not achieved in a short period of time. Obstructions of long duration suggest that a benign process is responsible. The patient is 63 years of age, and we are told she was well for 62 years. Yet it is possible for such a patient to have an asymptomatic ulcer for many years, slowly but relentlessly progressing to stenosis by scar tissue formation and obstruction. Such a patient may also have an acute ulcer in which edema of the mucosa and spasm of the pyloric sphincter muscle contribute greatly to the obstructing mechanism.

When you are dealing with pyloric obstruction of this degree and have very little to go on, the diagnosis is based on the synthesis of all the different types of evidence that you can obtain preoperatively. I wonder if in this case an exfoliative cytology was done? It is done in our institution quite routinely because we have one man, Dr. Raskin, dedicated to the idea and value of exfoliative cytology of the gastrointestinal tract. It does not depend so much upon the technic as upon the dedication of someone in the laboratory. Dr. Raskin's results have been spectacularly good. I would like to have had this information because it would guide me in deciding whether I should be prepared to do surgery for benign or malignant disease.

In this case I lean very strongly toward the diagnosis of a benign duodenal ulcer with edema, fibrosis, and fixation to the head of the pancreas. One cannot rule out gastric carcinoma; and if you think carcinoma cannot be a chronic disease, you may occasionally be wrong. Four years ago I saw a man in my clinic who said, "I want my operation now." The story was that he first came in and saw Dr. Walter Palmer because of constipation. In the work-up he was placed on a medical regimen and got rid of his constipation. When his x-rays were reviewed and the gastroscopic findings assembled and studied, it was definitely established that he had carcinoma of the stomach. He refused operation and did not reappear until four years later when he again had constipation. This time I operated upon him and found a gastric carcinoma, untreated for four years. But I doubt that carcinoma would ever develop such marked hypertrophy of the stomach as encountered here.

There are other possibilities. Perhaps this type of obstruction is due to some other duodenal pathology. We have other malignant tumors, such as leiomyosarcoma and malignant lymphomas, but I doubt that they are present here. There is no evidence of an intraabdominal mass and malignant myomas usually present as large masses in the stomach.

As for benign tumors of the duodenum, one must consider adenomas, hemangiomas, tumors arising in Brunner's glands, and other rare neoplasms. Hypertrophic pyloric stenosis of the adult type occasionally occurs, but most of the patients described fall into a slightly younger age group of 40 to 50 years. Since at least half of those described fall into this age group and this patient is 63, I think it is an unlikely cause.

I have seen only one case of adult hypertrophic pyloric stenosis. Other abnormalities include the superior mesenteric artery syndrome. It may be mentioned as a disease of much younger people. For a long time it was a debatable syndrome. I would not dare to diagnose it unless I had x-ray evidence of dilatation of the duodenum and a lateral view showing indentation of the duodenum by the passing of the mesenteric artery. These are rare, and I think that the best way to arrive at a successful diagnosis is to stick to the more common denominator, such as benign ulcer-producing obstruction.

It is sometimes a good thing to be stimulated by a challenging problem like this one and to see if one can arrive at a successful diagnosis. I think there are too many factors missing here

to permit a successful and binding diagnosis. I would certainly agree with the judgment that prolonged diagnostic endeavors could be bypassed by early laparotomy, just as soon as the electrolytes and water have been restored preoperatively to stable and satisfactory levels. It is interesting that histamine stimulation produced only 32 units of free acid. This is a low acid value for patients with peptic ulcer but, after all, in an obstructed stomach and one that may have contained food, it is possible that this is not accurate or does not represent the ordinary, usual histamine reaction of this patient's stomach. The relatively low free acid would suggest a gastric ulcer, perhaps a pyloric channel ulcer, but we have x-ray evidence that there is a defect in the duodenum. Whether this defect is ulcer or an incompletely filled pseudodiverticulum it is impossible to state. I am anxious to know what actually was found and what type of operation was performed.

Dr. Freeark: Before revealing the findings at surgery, I am interested in your statement that surgery is indicated as soon as the electrolytes and fluids are restored, and that perhaps this is the quickest way to diagnosis and therapy. Is a stomach that has been obstructed for 7 months a good one to operate upon? Will this patient be ready for surgery in 2 or 3 days or would you take longer in preparation?

Dr. Prohaska: I think a stomach as distended as this is not a good one to operate upon. The chances are that the wall would be thick and edematous. There is marked hypertrophy of the blood vessels. If there is an acute edematous ulcer, the blood supply to the duodenum might be compromised and you would be limited in your choice of operative procedure. An anastomotic opening that was adequate in this dilated stomach may prove functionless when the stomach returns to normal size. In this case we should not dogmatically say that she should be operated upon as soon as the electrolytes and water and chlorides are restored. I maintain that the stomach should be decompressed, and I take it for granted that this would be continued for several days. In some cases of obstruction, once you decompress the stomach for a few days and put the patient on ulcer management, the obstruction will improve. With too rapid return to regular diet the stomach again becomes distended and requires decompression and further electrolyte replacement. Any patient who remains on continuous nasogastric suction for too long a period rapidly deteriorates because he cannot be given much caloric intake intravenously. I think you have to "play it by ear." As soon as the stomach is decompressed and other measures are being done simultaneously and her blood is good, then I would go right ahead with surgery.

Dr. Freeark: I was sure that was what you meant. And I am grateful that you emphasized the importance of decompression. So often the initial efforts are directed toward establishing a diagnosis with no attempt made to consider the mechanical problems that are going to present to the surgeon. We were thinking in terms of 7 to 10 days of preparation in such a patient with simultaneous efforts at diagnosis, decompression, and restoration of metabolic balance. We realize, of course, that in that length of time we will not put the 50 pounds back on her.

Dr. Prohaska, if you operated upon a patient like this and found a duodenal ulcer, what would you do?

Dr. Prohaska: If this were a duodenal ulcer in a lady 63 years old, I would do a bilateral vagotomy and a posterior gastrojejunostomy. I would suspect from the evidence I have that the duodenal and pyloric portions of the stomach were actually inoperable and not suitable for pyloroplasty in lieu of gastrojejunostomy. I would feel that resection of the stomach would be difficult because of the inflammation in the duodenal and pyloric areas which interferes with healing and offers a distinct possibility of injury to the common duct. I would give her the simplest procedure.

Dr. Freeark: What about gastrojejunostomy alone? Since the acid values are low, is vagotomy essential?

Dr. Prohaska: I do not have evidence that this ulcer is burned out, and this is always a risky assumption. Gastrojejunostomy will relieve her obstruction, but doing a gastrojejunostomy alone in a patient aged 63 without abolishing the vagal stimulus to gastric secretion is risky and she might come back in six months with a stomal ulcer. In this patient vagotomy should be very easy to accomplish and is an essential part of the operative treatment for duodenal ulcer.

QUESTION: Is the nasogastric suction continuous throughout the day and night until the patient is operated upon?

DR. PROHASKA: Yes, in this case that is what I would do. If you put in suction, leave the tube in until the time of operation and then, if we do a vagotomy and gastrojejunostomy, we would remove this Levine tube and put in a gastrostomy, using a Foley catheter. Remember that sectioning of the vagus not only abolishes cephalic secretory activity of the stomach but also interferes with its motor activity. Overdistention does occur. Prolonged decompression of the stomach is essential after vagotomy. It is so much more comfortable for the patient to bring this gastrostomy tube out through the abdominal wall than through the nose.

DR. SAMUEL HYMAN, department of gastroenterology: We often encounter considerable trouble with Levine tube suction in large distended stomachs which contain all sorts of debris and chunks of food. Since it is impossible to get this out with the standard nasogastric tube, often the house staff, instead of using the larger Ewald tube to empty the stomach, relies upon the Levine tube, which merely removes the supernatant fluid. They think everything is fine until the patient arrives in the x-ray department or operating room when the thick sediment becomes readily apparent. Problems in the care of these patients are multiplied when their stomachs are filled with barium. I would like to make a plea for the use of the Ewald tube to begin with. Empty the stomach properly, adequately and thoroughly, and then place the patient on intermittent or continuous Levine suction.

DR. FREEARK: Are you reluctant to send these patients for barium study when you suspect obstruction?

DR. PROHASKA: Yes, I am. We often send them with a special note to the radiologist that we suspect an obstruction. Then they use thinner barium and take appropriate measures to restrict the amount ingested.

QUESTION: Is there any need, with a low acid like this, to sterilize the stomach before surgery?

DR. PROHASKA: The stomach is never completely sterile, even with a high free acid, but in general, pathogenic bacteria are infrequent in the healthly stomach. There are some surgeons who use dilute hydrochloric acid in cases of achlorhydria. I don't think it is really necessary. If you follow a good, classical, aseptic operative procedure, you should not have trouble from the point of view of infection.

DR. FREEARK: This patient was operated upon by a senior surgical resident. He described a severe inflammatory process involving the pyloroduodenal area the likes of which he had not previously encountered and was frank to admit he could not tell whether it was an ulcer or carcinoma. It was apparent that there was little he could do about it if it proved to be carcinoma. He elected to do a vagotomy and a retrocolic gastrojejunostomy. She was operated upon some six years ago, and in the follow-up period she has gained weight and has continued in good health. All of this would support the preoperative opinion that this was a benign duodenal ulcer with severe reaction and obstruction.

Case 2

DR. FRANK BANICH, surgical resident: This 48 year old Negro male was admitted to the medical service of Cook County Hospital on Feb. 16, 1960, with a 10 day history of vomiting and epigastric pain which radiated through to the back. His past history included an admission to this hospital eight years previously when ulcer was suspected but not proven. Four years prior to admission he had repeated gastrointestinal studies and gastroscopy, through a private physician, which demonstrated a "peptic ulcer," and he was placed on appropriate medications and diet which he followed religiously. The present episode of pain was particularly severe and was unresponsive to the usual management. His private physician advised hospitalization.

General physical examination was unremarkable except for the presence of epigastric tenderness. His nutrition and hydration were normal.

Routine laboratory study and x-rays revealed a deformity of the duodenal bulb with considerable gastric retention, reported as 50 per cent at 6 hours and 30 per cent at 24 hours. The antral region of the stomach was poorly visualized, and there was evidence of a gastric ulcer on the lesser curvature side of the prepyloric area of the stomach.

Shortly after admission the patient's acute distress was relieved by continuous nasogastric

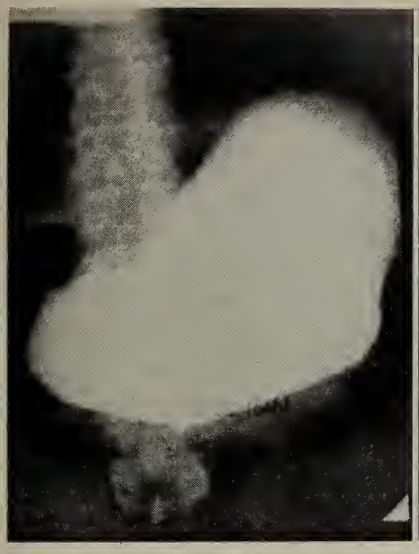


Figure 4



Figure 5

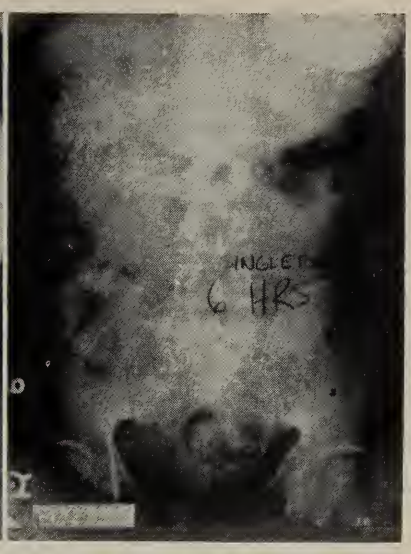


Figure 6

Case 2. Figure 4. Dilated stomach with no filling of antrum. Figure 5. Marked narrowing of antrum and deformity of duodenal bulb shown two hours after ingestion of barium. Note ulcer crater. After six hours (Fig. 6) less barium is retained; apparently the patient had vomited.

suction. Relief did not last, however, and following 10 days of strict Sippy management, he was transferred to surgery with intractable pain. Gastric analysis on the surgical service revealed:

February 18: 12 hour overnight secretion (continuous suction) returned 850 cc. with 32 clinical units of free acid

February 19: 10 hour aspiration, 1,500 cc., 26 clinical units

February 21: 12 hour aspiration, 1,100 cc. bile stained fluid with 20 clinical units

Laparotomy was performed on February 24.

Dr. Meszaros: The first x-ray film (Fig. 4) shows a large dilated stomach with no filling of the antrum. The next (Fig. 5) is the most important slide in both cases. There is marked narrowing of the antrum of the stomach and deformity of the duodenal bulb. There is an ulcer crater in this region. We have seen duodenal and small gastric ulcers that cause severe antral spasm and gastritis, but we cannot definitely rule out gastric carcinoma. At 2 hours we see very little barium going through. At 6 hours (Fig. 6) apparently the patient vomited because there is less barium. The 24 hour film shows organic obstruction with delayed emptying and marked retention in the stomach.

An important point is that the stomach should be empty at the time of radiologic examination. If the stomach contains retained food and secretions, the radiologist can state only that there is "pyloric obstruction," and differentiation between duodenal and antral lesions is unreliable and frequently impossible. In addition, we have frequently seen small and large ulcer craters obscured by food particles.

Dr. Freeark: The radiologist's diagnosis of organic obstruction is made on the 24 hour film. How about the 6 hour film? Is it of value?

Dr. Meszaros: I have seen almost complete retention at 6 hours due to spasm. However, this is unusual. The 6 hour film is a good indication of obstruction, especially if there is more than 20 per cent retention.

Dr. Freeark: I hope you all take to heart the advice that these patients be sent to the x-ray department after a night of careful aspiration and suction because it makes the study more valuable.

We thought this case was different from the first. The history is shorter, his acid values are more complete, and he has not done quite so much vomiting. How do you put these factors together? Is there a clear-cut indication for surgery in this middle aged individual?

Dr. Prohaska: The history was really pretty long. The obstruction history is short, but his ulcer history was of at least eight years' duration, and he is 48 years old.

There is some information here that one should really appreciate. In the first place, this man had intractable pain and night pain, and that suggests (1) obstruction or (2) an ulcer that has perforated to a neighboring organ. Those ulcers no longer respond to ulcer management. They will respond to morphine, of course, so I think he has, on the basis of this intractable pain, extension of the process, be it inflammatory or malignant. He must have an extension of this process to a neighboring organ, perhaps the head or the body of the pancreas, perhaps the transverse mesocolon. I have even seen penetration into the gallbladder from an ulcer in the duodenum.

This is probably the most significant film (Fig. 4) and I would agree with the other speakers that attempts at roentgenologic diagnosis have been compromised here because, if the stomach is full, you cannot make a good picture.

One has to consider in this instance a benign ulcer in the pyloric channel with very marked edema and spasm, but one must always think of carcinoma of the pylorus. Note that the distention and enlargement of the stomach are not as severe as they were in the other patient who fitted nicely into the picture of a benign duodenal ulcer. You could go through all kinds of differential diagnoses in this case, and you would be more successful if you think of the more common lesions. However, always run over the many varieties of strange lesions because only in that way can you avoid stereotyped thinking. Differential diagnosis is not only the bugbear of students; it is the mental exercise of the older surgeon too, and it is desirable to exercise it. For example, a few years ago we had a boy 17 years of age who had tarry stools now and then and nobody diagnosed it except the junior medical student who said it was a Meckel's diverticulum. Nobody seriously entertained this thought, and x-rays could not prove it; but at operation the student was right. He made the diagnosis because he considered it in the long list of diagnostic possibilities.

This man has a fair amount of hydrochloric acid, 850 cc. with 32 clinical units. I estimate that that would be about 20 mEq. of free acid, which is not very high. He had no masses palpable, and no report of cytologic examination is available. What was his blood count?

Dr. Freeark: It was normal.

Dr. Prohaska: It is harder for me to be absolutely sure that this man has a benign lesion. I would think that it is, and I will stick my neck out and say it is a benign channel or pyloric canal ulcer. He may have two ulcers, the channel ulcer of the stomach and a duodenal ulcer. I would prepare him for surgery. With an eight year history of ulcer, chances are that the history would repeat itself, and I think he has a pyloric obstruction. There is a great deal that goes into making a judgment and decision as to whether or not to operate on an ulcer. You have to deal with the patient's social and family background and determine whether he would be a good patient for medical management. In this case there is enough of a defect that he will not get well without surgery. It has been shown that this man on intensive hospital ulcer management for eight days did not do well. This is most likely a benign disease, an ulcer of the pylorus or duodenum with extension of the ulcer to the head of the pancreas.

Dr. Freeark: Most of the outstanding work on gastric physiology and the measurement of its secretions has come from the institution Dr. Prohaska represents. He was reluctant to expose his mathematical prowess by estimating the milliequivalents of hydrochloric acid secreted by this stomach, and we purposely avoided it so that he would have to emphasize its importance. If one measures the liters obtained in the aspiration of a stomach over a 12 hour period during a night's sleep and multiplies that figure by the clinical units, one gets the milliequivalents of free hydrochloric acid that that stomach is capable of producing. The normal range is between 18 and 22 mEq./L. Patients with duodenal ulcer have from 3 to 20 times that much. In contrast, patients with a benign gastric ulcer usually have normal or lower than normal values. Our patient has relatively normal values. His stomach is not decompensated in the same sense that the previous patient's was. Does this alter your working diagnosis? How much emphasis do you place on this gastric analysis?

Dr. Prohaska: First I want to say something about a decompensated stomach. If you have a stomach that is obstructed for a short time, the presence of any substance in the stomach, be it food or some other foreign material,

even a distended balloon like a 30 cc. Foley catheter, will stimulate the gastric phase of secretion. But a chronically obstructed stomach will suffer decompensation, and the mechanism and capacity for gastric secretion is upset. We know in this case the man did secrete acid.

Dr. Freeark: If he did not secrete any acid at all, even on histamine stimulation, what would you say?

Dr. Prohaska: It could still be a benign gastric ulcer but that does not happen often. It favors the diagnosis of carcinoma.

Dr. Freeark: Dr. Lichtenstein, have you an opinion on this case?

Dr. Manuel Lichtenstein, chairman, department of surgery: The opinions expressed by Dr. Prohaska are as sound as those expressed by Sippy or Palmer or the other great gastroenterologists of this country. Perhaps some of you are unaware of the fact that Walter Palmer did much of his work in this hospital. When I was an intern he was a resident, and he spent many hours doing gastric analyses on the patients of Cook County Hospital. Valuable information is readily available here.

I am glad to hear about long periods of decompression. You need not think only in terms of a long period of decompression because you are doing other things to rehabilitate the patient and make him a favorable subject for any operative procedure. The mistakes in these patients have been due to too prompt operative procedures on a stomach whose wall was not fit for healing processes in any type of surgical procedure. I think emphasis on this point in the first case is most beneficial. Some of these things that were emphasized years ago have been overlooked by some of the "blitz surgeons" who acquire a technic and use it just to manifest skill but without the judgment necessary to guarantee a good result.

In the second case the situation is different. It occurred to me that a person who has a duodenal ulcer that compromises the outlet to the stomach may incur sufficient gastric stimulation of acid secretion to develop a gastric ulcer. It is not uncommon in a person who has an obstructive duodenal ulcer to have a gastric lesion too. That may account for some of the findings in this patient.

In Dr. Prohaska's discussion of the first case, he talked about the adult type of pyloric stenosis. Two types of pyloric stenosis have been described in adults, and some years ago we presented five patients with the adult type of hypertrophic pyloric stenosis. All patients had obstruction and hypertrophy. Two patients had primary disease of the pyloric muscle with no distal disease. A secondary type of hypertrophied pyloric sphincter is seen in duodenal ulcer or in disease involving the duodenum. The benign type of primary hypertrophic pyloric stenosis is possible, but I would agree that in this case it is most likely spasm related to a channel ulcer. The possibility of carcinoma is always present, but the roentgenologist, with improved technics, can often pinpoint these lesions as benign or malignant or point out characteristics that will aid in the diagnosis.

There is a possibility of tumor mass here, but spasm from ulcer or without ulcer may give the same type of picture. It is commonly diagnosed as carcinoma but none is found at operation.

Dr. Freeark: This patient was explored and, as Dr. Prohaska predicted, he had a benign ulcer penetrating deeply into the pancreas. It arose from the lesser curvature of the stomach in the prepyloric or antral area. The duodenum was perfectly normal. There was no evidence of duodenal obstruction or significant external evidence of duodenal scarring. We wonder if this was one of the group of cases of hypotonicity with a primary gastric ulcer. The acid values would be in keeping with that. We wonder whether you subscribe to the theory that a primary gastric ulcer results from hypomotility with antral retention and that this is the etiology of this man's complaints. An alternative would be to call this gastric ulcer a secondary one, that is, secondary to an obstructing duodenal ulcer that caused antral retention and stimulation. There was little evidence of this.

Dr. Prohaska: I would favor the idea of a mechanical obstruction due to pre-existing duodenal ulcer which has healed and produced a silent obstruction or narrowing due to scarring rather than to use a term like hypomotility. I don't know how to explain the cause of hypomotility of the stomach. I would say that this man had an eight year history of duodenal ulcer which healed with imperceptible scarring: then he developed a pyloric or antral gastric ulcer.

Dr. Freeark: What operative procedure do you recommend for gastric ulcers either alone or with duodenal ulcers?

Dr. Prohaska: I make a decision based on the 12 hour night secretion. If that patient had more than 25 mEq./L. in his overnight secretion, we would do vagotomy and a small gastric resection, maybe 50 per cent, at any rate enough to be sure we have taken the ulcer out. Then we would do a Billroth I or Hofmeister reconstruction.

Question: How would you diagnose a primary gastric ulcer?

Dr. Prohaska: You could diagnose this by giving the patient a motor meal. If there was no retention, you would say this could not be due to partial obstruction of the duodenum producing gastric retention. In the absence of gastric retention, you would have to explain a primary gastric ulcer on the basis of hyperfunction of the antral phase of gastric secretion.

Dr. Freeark: Dr. Prohaska, we are all most appreciative of your very fine observations and discussion. You have greatly facilitated our approach to this difficult problem of pyloric obstruction.

Summary and conclusions

1. Interference with gastric emptying in adults is most commonly due to peptic ulcer or gastric carcinoma. Rarer causes include hypertrophic pyloric stenosis, previous acid ingestion, and foreign bodies.

2. When the obstruction has existed for some time, the classic complaints of cramplike pains, nausea, and vomiting may decrease in severity or even disappear. The differential diagnosis of benign from malignant pyloric obstruction is as often made by clinical means as by radiologic, although at times it is impossible prior to surgery. The characteristics of benign obstruction are:

a. Previous ulcer history.
b. Gastric acidity which may be normal or even low in the presence of persistent gastric obstruction.
c. Marked degrees of electrolyte imbalance, the result of losses of large amounts of gastric acids.
d. Relief of obstruction on conservative measures.

The characteristics of malignant obstruction are:

a. Achlorhydria to histamine stimulator.
b. Failure to relent on conservative measures.
c. Smaller stomachs for the duration of obstruction.
d. Palpable abdominal tumor.
e. Severe anemia.

3. Physical findings are often limited to the presence of upper abdominal distention and a succusion splash on manipulation of the abdomen. Peristaltic waves may be noted.

4. Electrolyte disturbances result from the loss of hydrochloric acid in the vomitus and are usually more marked in benign disease. The accompanying loss of the large amount of potassium ion present in both saliva and gastric juice is often overlooked.

5. While opinions differ as to the time required to prepare an obstructed stomach for surgical intervention, efforts should be made to achieve:

a. Restoration of fluid and electrolyte balance.
b. Mechanical evacuation of the stomach which often contains the undigested food, barium, and a highly pathogenic bacterial flora.
c. Reduction in the edema and vascularity of the stomach wall in an attempt to render it more suitable for surgery.

The restoration of the nutritional status of the patient is felt by some to be more readily achieved by immediate surgery, while others contend that such patients are unsuitable surgical risks.

6. The pathology of obstruction due to peptic ulcer may be edema at the pylorus, muscle spasm, or cicatricial scarring. In addition, the overdistended stomach is incapable of its normal propulsive activity. Three of these mechanisms may be considered reversible without operative intervention. A suggested regime for pyloric obstruction would be as follows:

a. On admission insert an Ewald tube and evacuate with repeated washings all of the gastric residue.
b. Insert a Levine tube and maintain continuous nasogastric suction with vigorous attempts to restore pre-existing fluid and electrolyte deficits and continued losses (1 to 3 days).
c. With relief of obstruction as judged by the return of bile in the Levine or decreased

gastric volume, the patient may be started on a liquid diet during the day with continuous aspiration of residual diet or secretion during the night.

d. Rapid progress to a more nutritious, low residue diet is in order depending upon the ability of the stomach to evacuate it.

e. Nightly aspirations, four hours after the evening meal, may be continued for some time while the nutritional status is being restored.

7. The treatment of pyloric obstruction depends upon the underlying etiology. For benign duodenal ulcer the treatment of choice is vagotomy with gastroenterostomy. Attempts to resect a dilated stomach are often hazardous, and the omission of vagotomy, even when gastric acidity appears low, is unwise. In many patients the hypoacidity reflects gastric decompensation resulting from obstruction, and when obstruction is relieved, hyperacidity returns.

Council Meetings

Chicago

1961

June 10 and 11

July 15 and 16

September 16 and 17

November 18 and 19

1962

January 13 and 14

March 17 and 18

Annual Meeting, May 13-17

AMA — Chicago, June 25-29

Influence of the Doctor–Patient Relationship On Drug Action

Eric C. Kast, M.D., and John Loesch, M.D., *Chicago*

Many factors have to be accounted for in the clinical process of drug evaluation. Simple observation of the patient's well-being following drug administration often gives a distorted picture because of possible bias in the doctor as well as in the patient. Concealing the experimental aspect of drug evaluation from the patient diminishes his intensive self-observation and thus yields more reliable results. These considerations produced the double blind test, in which neither doctor nor patient knows when the new medicine is administered. Bias, scepticism, and indifference are some of the distorting variables removed by the double blind test.[1]

We believe, however, that the enthusiasm of the doctor, rather than bias, actually alters the therapeutic response, and that the influence of this enthusiam on the patient's well-being is not removed by the double blind test.[2]

A patient, finding himself in an unknown and frightening environment, watches his position carefully, often invoking fantasy and unrealistic considerations.[4] For orientation he observes external signals from his medical environment, and his own internal signals that indicate to him the harmful and helpful effects of his external environment.

It is the external signals, which have been studied[2] and found to have a profound influence on the patient's well-being, that are largely removed by the double blind test.

Internal signaling consists of a subjective interpretation of pharmacological phenomena and is determined by the doctor-patient relationship. Mild therapeutic effects of a chemical substance, interpreted in the light of a helpful medical environment, may be considered as heralding a long-sought improvement. An enthusiastic doctor might influence the patient to interpret the therapeutic results as being much greater than they would be in a different medical environment. Toxic symptoms (so-called side effects) are subject to the same interpretations. They may, if interpreted in a positive way, indicate to the patient the power of the physician over illness and to alleviate discomfort. If the patient fears the power of the physician, side effects may be interpreted as harmful. Both interpretations of therapeutic results elude the double blind test.

This study is concerned with the delineation and quantitation of the potential influence of internal signaling on clinical experimental drug evaluation.

Method

Twenty patients (8 men, 12 women) with functional digestive disorders without organic pathology were selected from a free medical clinic. Their mean age was thirty-six. They had reasonably homogeneous economic, cultural, and social backgrounds. They showed considerable dependency on the clinic, were rather suggestible, and were able to articulate adequately for evaluation. They were completely studied from a medical and gastrointestinal standpoint. Although one had a history of duodenal peptic ulcer and two had evidence of diverticulosis, these conditions were not thought to contribute to the picture of functional bowel disorder.

They were treated with meprobamate and tridihexyliodide[5]* and given mild dietary restrictions, consisting of elimination of mechanical and chemical irritants.

The patient population was divided into two group. One group of ten patients was handled with special care. They were seen at weekly intervals, and more time was spent with them than usual; they did not have to wait to be seen, and the doctors were available at all times for telephone consultations. All clinical facilities

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were used to emphasize to these patients that they were well taken care of and that the doctors had the power to help them. This phase was called DP1 (doctor-patient relationship-1).

After this regime was stabilized, the patients were divided into two sub-groups of five each. To one group of patients we added a new drug, atropine sulfate 0.6 mg., three times a day. We cautioned these patients of the possibility of a toxic side effect: a dry mouth. This, we stated, was dangerous and a sign that the medicine should be discontinued. To the other sub-group of five patients we gave the identical dosage of atropine, forewarning them of a dry mouth, and stating that this was a sign that the medicine was working and that the patient should ignore it.

The second section of the initial patient population was treated with less concern. We saw them at biweekly intervals for a shorter period of time; we were not available except at the appointed time; and most clinical facilities were used to emphasize indifference. This phase was called DP2 (doctor-patient relationship-2). After a four to six week period of stabilization we divided this group again into two sections and added to the therapy of both groups atropine sulfate in the same dosage and with the same interpreting remarks.

We evaluated the patient's sense of well-being on a controlled but intuitive basis because the subtleties and innuendoes of a patient's communication usually escape mechanistic means of evaluation[6]. Two experienced physicians made independent evaluations. We applied a rating scale of one to eight in order to allow for minor shifts in the patient's mood and disposition. A rating of one indicated marked deterioration and eight showed maximum improvement; four represented maintenance of the status quo. Such a rating scale does not impose a dichotomy between improvement and deterioration, but represents the continuum between these states, symbolically and statistically.

All material was statistically evaluated and the degrees of confidence are noted in the result.

Results

Under DP1, the first phase, the mean rating per patient was 6.4. This was achieved partially by medication and diet and to a certain extent by the patients' belief in our power and ability to help. After we gave atropine sulfate along with some cautioning remarks to this group, the improvement rate dropped to an average of 3.9 per patient. The p-value for this drop is .02*. We maintained the same medication and the same clinical management. The second subgroup under DP1, receiving the identical medication but with encouraging remarks, yielded a mean improvement rating of 6.8, not significantly different from the control group under DP1.

The control period with DP2 as governing relationship with medication and dietary management identical to DP1 yielded a mean improvement rate of 4.9. The difference between this rate of improvement and that under DP1 is statistically significant ($p = .05$). In the first subgroup under DP2, where atropine was given with cautioning remarks, the mean improvement rating was reduced to 3.2 ($p = .01$). Under the same management with the same medication but with encouraging remarks about side effects, the mean improvement rating was 5.6 ($p = .02$).

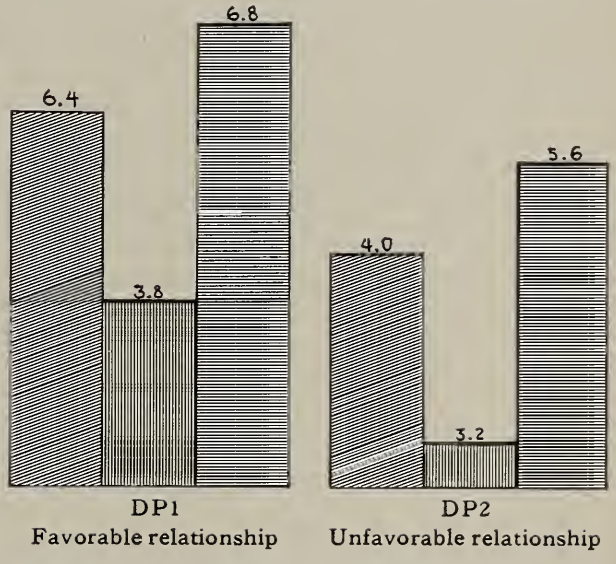


Figure 1. Diagonal strip: control period (p.-.05)
Vertical stripe: side effect interpreted as dangerous (p.-.02, .01)
Horizontal stripe: side effect interpreted as evidence that drug was working (p.-.02)

**P-value indicates the probability, expressed in terms of decimal fractions, of an event occurring by chance (Fisher tables). For instance, a p-value of .01 corresponds to 1% or 1 chance in 100 for the event to occur by chance.*

Discussion

It has been recognized for a long time that the medical environment deeply influences the readiness of the patient to respond to "treatment."[3,6] One phase of this readiness of response is related to changes in the patient's homeostasis, attributed by him to medical influence, and his interpretation of these changes. It has been shown that these changes need not be directly connected with deliberate medical interference but may be engendered by coincidental events: diagnostic procedures or gastrointestinal or cardiovascular sensations concomitant with the excitation of a visit to the physician[2]. These internal changes (when attributed by the patient to the medical environment) and their interpretation we called internal signaling. In order to assess the contribution of internal signaling to the distortion of new drug evaluation, we deliberately produced harmless signals (dry mouth) by use of atropine. We interpreted this signal to the patient as helpful or harmful, and observed the impact of this simple interpretation on the patient's general sense of well-being.

Patients scrutinize themselves very carefully and watch for evidence that the physician has the power to heal. As with most powerful influences, the response to them is twofold. On one hand, the patient gives himself up to this power and has "faith" in the benevolence of the physician; on the other, if the internal structure of the patient is such as to distrust dependent relationships, even mild therapeutic results of treatment may be interpreted as signs of dangerous loss of control, thus harmful.

This has been evident, for example, in the case of tranquilizers, which produce a certain passivity and bring out fears of dependency.[4] The patient is frightened by this, if his personality and his relationship to the medical environment cause him to associate dependency with danger.[4]

In a previous study we varied the improvement rate of functional digestive disturbances by modifying the medical environment alone; the present investigation substantiates the first. The power of the medical environment (external signaling) is shown in this study by the difference between the improvement ratings under DP1 and DP2. The sense of well-being of the patient is further modified in this study by internal signaling. In commenting on expected side effects we labeled our influence over the patient as beneficial or harmful and obtained the corresponding results. The activity of a drug, of known and proven potency, was varied from a mean effectiveness rating of 6.4 (DP1 and positive internal signaling) to a rating of 3.2 with negative signaling from the outside as well as from the inside of the patient (DP2 and negative internal signaling).

In the evaluation of new drugs of subjective action, the double blind test is effective in eliminating the so-called placebo reaction, but it deals with all drugs as though they were placebos with no pharmacological action. It does not take into account the patient's interpretation of the changes in himself, engendered either by deliberate therapeutic interference, by toxic manifestations, by diagnostic procedures or by coincidental sensations. These changes, as we have shown, are subject to intensive interpretation. In this study we interpreted the internal signals intentionally, but in the ordinary course of events the patient interprets these signals according to his own needs. This interpretation can probably be predicted from an examination of the external medical environment and the patient's attitude towards it.

Summary and conclusion

This study is an attempt to explore and quantitate the influence of side effects on pharmacological evaluation.

The medical interrelationship between patient and physician can be divided into two parts. One consists of the impressions the patient gains from his environment and their interpretations, which we called external signals. The second, internal signals, consists of changes in the sense of well-being of the patient attributed to the beneficial or harmful influence of the medical authority and caused either by therapeutically intended action, toxic action, or coincidentally produced sensations.

By varying the external environment (external signals) we were able to modify the therapeutic efficacy of meprobamate and tridihexyliodide from a mean improvement rating of 6.4 under a favorable doctor-patient relationship to a mean improvement rating of 4.9 with an unfavorable doctor-patient relationship. Furthermore, when artificially produced internal signaling (a dry mouth produced by the administration of atropine) was interpreted favorably as heralding

medicinal action, the mean improvement rating went up to 6.8. In the negative doctor-patient relationship phase of the study, when the same signals were interpreted negatively, the rating dropped to 3.2. This considerable variation in drug efficacy was obtained with the same drug given under various different circumstances.

We feel that this variation has probably contributed materially to errors in clinical drug evaluation. In addition to using the double blind test, we propose to test new drugs by deliberately varying the external environment and by positive and negative interpretations of internal signals. In this way the vicissitudes of the medical relationship are not removed to a less informative average, but stabilized, deliberately varied, and accounted for.

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Concentrated Dry Frozen Baby Food

An Abstract

People will be asking for your opinion of dry frozen baby foods. The new method of preparation takes advantage of the nutrient retention properties of freezing and includes three established procedures — limited application of heat, reduction of moisture, and freezing. Both moisture and temperature reductions are carried out in a matter of seconds. The new food consists of minute free-flowing flakes in which the natural colors, fresh flavors, and nutrients are retained in high degree. Reconstitution is accomplished by the addition of water. For maximal retention of freshness the product is handled as a frozen food.

"The food was accepted by all infants in the study and was preferred by mothers who had had experience with other strained foods." The mean height and weight curves of the infants closely approximated the mean of the Iowa Growth Standards. "Infant acceptance, general health, stool pattern, growth and development were found to be normal." All mothers "preferred this new product with respect to ease of preparation and storage."

This clinical study was supervised by Dr. Robert Jackson, a member of the Council on Foods and Nutrition of the A.M.A. — *Van Leeuwen, G. J., Guyer, E. J. and Jackson, R. L. Am. J. Dis. Child. 101:18 (Jan.) 1961.*

James R. Wilson, M.D.

THE VIEW BOX

Franz Gampl, M.D., *Chicago*

The patient, a 22 year old Negro female, was hospitalized after suffering for a week with periumbilical cramping pain, nausea, and diarrhea with up to one bowel movement every 10 minutes. She reported also that blood was present in the stools. During the last few days she had had occasional blurring of vision.

Her past history revealed similar attacks since the age of 14. One of these required hospitalization elsewhere one year before, at which time she received two pints of blood.



Figure 1. Pre-evacuation study



Figure 2. Postevacuation study

The physical examination revealed a tall, thin, pale Negro female in moderate abdominal distress. The pulse was 100/minute and regular, the blood pressure 110/80, and the respiratory rate was 20/minute. The abdomen was somewhat distended, the abdominal walls were soft, and there was generalized tenderness to palpation, especially in the area of the left lower quadrant. There were no abnormal soft tissue masses. The bowel sounds were active. Fresh blood was found on rectal examination.

Barium studies of the large bowel were done.

What is your diagnosis:

1) Regional colitis
2) Diffuse polyposis of the colon
3) Amebic dysentery
4) Chronic nonspecific ulcerative colitis

From the radiology department, Cook County Hospital

(*continued on page* 397)

Opinions that are well rooted should grow and change like a healthy tree. *Irving Batchèller*

MEDICINE IN THE OUT-OF-DOORS



Touring

JULIUS M. KOWALSKI, M.D., *Princeton*

We are a nation of tourists and much of this travel is done in autos over an enlarging network of super-highways. A family unit of parents, children, and one or two elder citizens can make a three or four thousand mile trip without thought to hardships and lengthy difficult detours, or where they will eat or sleep. The latter irksome problems are no more, thanks to the cooperative efforts of the various states and motor clubs.

Patients frequently seek advice from their physicians concerning specific problems relating to lengthy auto travel or to unfamiliar areas. Some of these topics will be discussed briefly.

Contemplated travel into mountainous areas by "low-landers," particularly elderly persons, may give rise to questions or apprehension. The highest mountain highway passes in the western states are about 10,000 feet or less. The answer to the question, "Could I stand such altitude?" will be found in the fact that commercial air lines have their planes pressurized to this altitude though the flights are made at much higher altitudes. A categorical answer to questions regarding altitude tolerance is found in a recent report on medical criteria for passenger flying on scheduled commercial flights issued jointly by the American Medical Association and the Aerospace Medical Association: "A person who looks normal, feels normal, smells normal, and can walk up the steps of a ramp, can fly without likelihood of difficulty." Remembering the humiliating defeat of the U. S. Track Team in the Pan American Games at Mexico City several years ago when our boys literally collapsed en masse, acclimatization should be pointed up.

Strenuous physical activities such as lengthy hikes or mountain climbing must be preceded by four to six weeks' conditioning at the altitude where they will eventually be carried out. Obviously, such stringent requirements will be met by only a handful of zealous individuals. Conditions affecting the greatest number of travelers at altitude are referable to the cardiovascular and pulmonary systems. In general, anyone — from child to octogenerian — who is healthy and active daily and not under medical care can safely tour the mountainous states.

Now to touch upon a few specifiics:

- Anemias which are stabilized and checked at four-week or longer intervals should present no difficulties.
- Cardiac decompensation is no bar to travel if the patient is stabilized and can pursue his ordinary physical activities without undue fatigue, palpitation, dyspnea, or anginal pain.
- Hypertension, if controlled, does not preclude such travel. Those prone to epistaxis may find its frequency increased. Smaller doses of sedative may be necessary.

• Cerebrovascular accident patients who have recovered sufficiently to be back at full time activity can participate in travel.

• Coronary and angina patients who currently are performing the tasks they did prior to their illness and have no residua surely can travel. Vasodilators and anticoagulants as usually taken by these patients do not produce untoward reactions at these altitudes.

In general, patients with cardiovascular conditions who fall into Class A or Class B of the therapeutic classification of the American Heart Association are capable of long tours through mountainous areas.

• Asthmatics who are under effective control with medication and do not over-exert themselves should have no more than temporary adjustment problems. The same applies to allergic individuals, but consideration must be given to heavy exposure to conifer, sage, and other unusual allergens.

• Persons prone to upper respiratory infections which are precipitated by weather extremes should anticipate recurrences. Daily temperature fluctuations in mountainous areas may be as much as 40 to 50 degrees. By mid-morning (in summer) the days are usually clear and warm, but often windy. In late afternoon brief showers are common, and at night the temperatures frequently drop into the 30's. Wearing appropriate clothing and rain gear can minimize upper respiratory miseries. Aerosinusitis and aerotitis can be troublesome in rapid descents. Yawning, swallowing, and clearing the respiratory passages help equalize the pressures and often alleviate these conditions.

• Dental caries often become troublesome and more painful after travel from low altitudes to 7,500 feet or higher due to aerodontia. What was a tolerable sore tooth at sea level, in a mountain pass becomes the devil's anvil.

• Pregnancy is no bar to travel up to the eighth month, provided there are no complications. Frequent stops for the prospective mother — every two to three hours — are advisable for elimination and postural change.

• Healthy children are verily indestructible and adjust quickly to travel. Diet, gastrointestinal upsets, constipation, and motion sickness are the more frequent problems in traveling youngsters.

• Immunizations — polio for those under age 40, and tetanus toxoid for any age group — are a must always, but especially so while traveling.

Knowing one's blood type, a valuable bit of information at any time, can be life-saving in an acute emergency.

A few suggestions about automobile travel that can make it safer and pleasanter:

If one feels he is getting tired, STOP — RIGHT NOW! Walk around the car, stretch, take six deep breaths; a cup of coffee often helps. Make it a rule to stop every two to three hours, regardless. Get on the road early and stop in the late afternoon or early evening. Avoid nighttime driving if at all possible.

If fatigued, be man enough to call it quits and get some sleep. Use of cerebral stimulants and sleep-inhibiting drugs is mentioned only to be condemned. Never, under any circumstances, use them while driving.

Sunglasses ease eye strain even if the day is not too sunny. Headache, lassitude, and constipation while driving for long periods are often due to dehydration. Drink plenty of water or juices. Motion sickness in children and pregnant women is well controlled by a number of medicaments.

The heinous morbidity and mortality accruing from highway accidents could be substantially reduced by the use of seat belts. At least 5,000 lives could be saved annually if seat belts were used at all times in highway driving. Comparable losses in military combat would bring out screaming newspaper headlines and severe censure of the commanders.

The above discussion, though of necessity general in scope, covers areas which frequently prompt questions from patients contemplating a long tour. Specific answers for definite problems can be given only by the doctor who is conversant with the patient's history and findings, but this resumé can prove helpful to both.

Every man is his own ancestor, and every man his own heir. He devises his own future, and he inherits his own past. — H. F. Hedge

The View Box—diagnosis and discussion *(continued from page 394)*

The diagnosis is chronic nonspecific ulcerative colitis.

The radiographic findings are demonstrated on the three illustrations. The loss of the normal haustral markings of the colon results in a ribbon-like appearance. The jagged, irregular contours are due to pseudopolyposis or cobblestoning, represented by islands of hypertrophied mucosa remaining between areas of ulceration. The colon is shortened and has lost its normal redundancy, secondary to severe fibrosis and scarring. This is characteristic of the chronic stage of the disease. The involvement is almost uniform, most pronounced in the descending and the transverse colon. The ascending colon was less involved and retained deep haustra in its proximal portion.

Typical cases of nonspecific ulcerative colitis are easily differentiated from the specific (tuberculous) and nonspecific (regional enteritis) granulomatous diseases of the colon, which are more localized. The barium-filled colon reveals areas of uninvolved bowel, pressure from enlarged mesenteric nodes and abscesses, and fistula formation; these are diagnostic aids in granulomatous disease.

In diffuse polyposis of the colon the haustral markings and the normal redundancy of the bowel are preserved.

It may be impossible to differentiate amebic colitis from the nonspecific ulcerative type; the predilection of the organism for the right hemicolon and cecum, however, may suggest the correct etiology.

Nonspecific ulcerative colitis, although most commonly found in the left hemicolon and rectosigmoid may extend throughout the entire colon. Involvement may also occur beyond the ileocecal valve (backwash-ileitis). Early stages of the process are best diagnosed by proctoscopy. The roentgen examination is normal until edema of the mucosal folds and ulcerations occur, recognizable by enlargement of the mucosal folds and serrated appearance of the contours of the bowel. The findings of the chronic stage are described above.

Local complications of ulcerative colitis include narrowing of the colon, perforation, and abscess and fistula formation. Pseudo-adenomatous polyps may show malignant changes in a high percentage (10%) of patients with chronic ulcerative colitis for 10 years or longer.

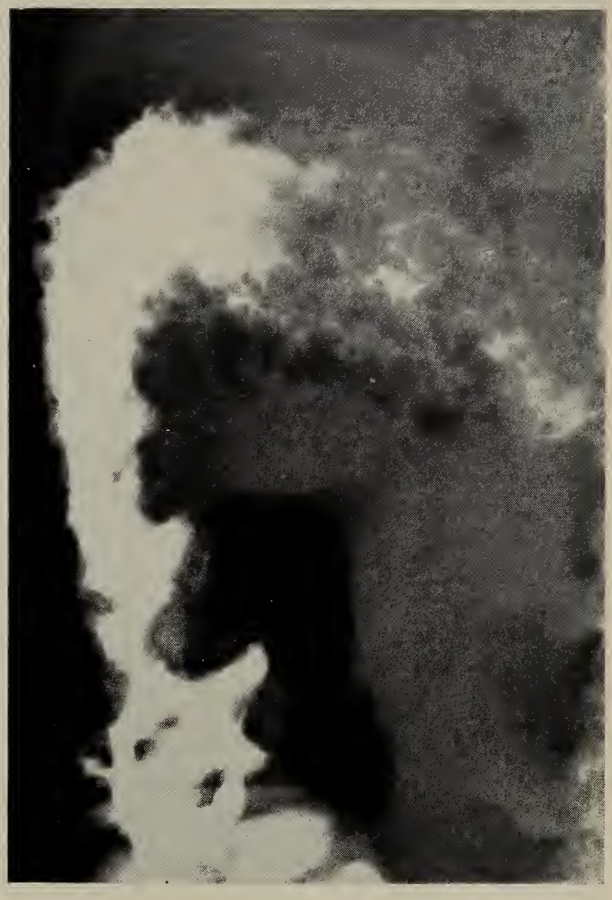


Figure 3. Cutout from the postevacuation study showing the cecum and the ascending colon with multiple large pseudopolyps and ulcerations of the mucosa.

Systemic complications of ulcerative colitis include nutritional deficiencies, anemia, osteoporosis, skin lesions, arthritis, fatty liver, myocarditis, and kidney damage.

If medical management is unsuccessful in controlling the disease, surgical intervention is reserved for such cases and for acute complications.

FURTHER READING

Feldman, M.: Clinical Roentgenology of the Digestive Tract. 4th ed. Baltimore, Williams & Wilkins, 1957. Pp. 441-449.
Marshak, R. H., and Wolf, B. S.: Roentgen Findings in Regional Enteritis, Am. J. Roentgenol. 74:1000-1013, 1955.

Effects of Fluphenazine Dihydrochloride In State Hospital Patients

Angelo Zocchi, M.D., and Konstantin Dimitri, M.D., *Galesburg*

The introduction of a new psychopharmacologic agent interests the physician in contact with refractory chronic psychotics. This clinical study concerns a new trifluoromethyl phenothiazine derivative, fluphenazine dihydrochloride (Prolixin®)*, which reportedly is more therapeutic in lower dosage and produces fewer side effects than previous phenothiazine compounds.

Methodology

In an attempt to limit the multitude of variables affecting any evaluation of a new psychopharmacologic agent, we have confined this evaluation of fluphenazine to two small groups of chronic but relatively young patients. The ward personnel and routine were kept constant, and relatively homogeneous patient groups were selected according to set criteria.

Selected patients were all chronic schizophrenics, except for three diagnosed as having sociopathic personality disturbance. The latter were included because of chronic elopement, destructiveness, belligerence, and combativeness. Selection was based essentially on the following criteria: (1) chronicity; (2) combativeness; (3) persistent delusions; (4) withdrawal and seclusiveness; (5) restlessness; (6) negligence in grooming and appearance; (7) disinterest in recreational and ward activities; and (8) poor response to other phenothiazine drugs.

Fluphenazine was administered to 14 male patients and 10 female patients. In addition to poor response to other tranquilizers, 10 patients previously had received electroshock therapy, and 3 also had received insulin coma therapy.

The patients ranged in age from 14 to 39 years of age and averaged 27 years. Duration of hospitalization was from 1 to 12 years and averaged 4.5 years.

TABLE 1. Types of Schizophrenic Patients Treated With Fluphenazine Dihydrochloride.

Diagnosis	Male	Female	Total
Schiz. Undifferentiated	7	5	12
Schiz. Paranoid	6	3	9
Sociopathic Personality	1	2	3
Total	14	10	24

Table I shows the diagnostic composition of the two groups.

All prior medications were discontinued for a period of seven days. At the end of this period a complete battery of blood and liver function tests were performed, and fluphenazine therapy was initiated. Laboratory studies were reported at three-week intervals during the first two months and every six weeks thereafter. Blood pressure and pulse were checked in orthostatic and horizontal positions twice a week for the first month and weekly thereafter.

Dosage

Fluphenazine was initiated at 5 to 10 mg. per day according to individual patient needs. After a period of 10 days, the dosage was gradually increased up to 50 mg. in some cases. Only in three patients was a single daily dose adequate in controlling symptomotology, but two daily doses administered in the early morning and afternoon proved effective in most patients who responded favorably to the drug. Maintenance dosage varied

Psychiatric Resident, and Clinical Director, respectively, Galesburg State Research Hospital.

**Fluphenazine Dihydrochloride (Prolixin) used in this study was provided by E. R. Squibb & Sons, Division of Olin Mathieson Chemical Corporation.*

from 5 to 30 mg. per day, and averaged 15 mg. per day.

Side reactions

At a daily dosage of 5 mg., tremulousness of the upper extremities and akathisia appeared in one male and three female patients.

Mild to moderate extrapyramidal symptoms were noted at a daily dosage level of 10 mg. or higher in 4 males and in almost all of the female patients. However, the addition of antiparkinson drugs easily controlled these symptoms.

Apparent aggravation of psychotic processes occurred in one male and one female patient, and the administration of fluphenazine had to be discontinued in both cases. However, it should be noted that these patients also showed a similar response to other phenothiazine derivatives.

Systolic blood pressure dropped 10 to 25 mm. Hg in the majority of patients, but within 10 days this returned to normal values.

Skin reactions of unexplained etiology occurred in the lower extremities of two young females. These appeared as symmetrical maculopapular lesions, which later developed into deep irregularly shaped ulcers.

Insomnia occurred in a few cases, but this complaint ceased when the drug was administered earlier in the day.

Clinical results

Evaluation of the clinical results was based upon a comparison of the patient's recorded symptoms, and mental status before therapy was initiated with summaries of repeated evaluations after initiation of fluphenazine therapy. Ward notes on patient behavior also were considered in the final evaluation. On the basis of this information, the results were rated as (1) *very good* when the psychopathological symptoms cleared up entirely and the patient exhibited more appropriate behavior and fairly good insight into his previous mental condition; (2) *good* when a marked reduction or absence of symptoms occurred, and personal appearance and social performance improved, but no insight into previous mental condition and very little amelioration of effect was noted; (3) *poor* when the condition of the patient remained unchanged or became worse.

Table 2 shows the results by sex and correlation to diagnostic categories.

TABLE 2. RESULTS OF TREATMENT OF SCHIZOPHRENIC PATIENTS.

Male			Diagnosis	Female		
Poor	Good	Very Good		Poor	Good	Very Good
4	3	—	Schiz. Undifferentiated	3	2	—
—	3	3	Schiz. Paranoid	—	2	1
1	—	—	Sociopathic Personality	1	1	—
5	6	3	Total	4	5	1

Discussion

At the dosage levels used in this study, fluphenazine appeared to be a safe and potent ataraxic drug which has some advantages over other phenothiazine derivatives. The negligible and transitory incidence of drowsiness, dizziness, and disturbance of gastrointestinal motility resulted in a less resistive attitude on the part of the patients taking the medication.

Laboratory studies during and after therapy failed to show any significant variation in blood and liver function tests. A patient of the male group who had just recovered from obstructive hepatitis due to another phenothiazine drug did not show any further involvement during and after treatment with fluphenazine.

Dystonic reactions occurred rather frequently. However, there was a prompt reversibility upon discontinuation of the drug or addition of antiparkinson medication. Primary factors governing the incidence of dystonic reactions seemed to be individual predisposition and possibly sex, with three females affected for every male.

No correlation was found between appearance and intensity of extrapyramidal symptoms and therapeutic response to the drug. On the other hand, a positive clinical response to the administration of fluphenazine generally appeared within the first three weeks of treatment and at a minimal dose of 5 mg. per day.

Improvement, when observed, came in progressive steps. First a reduction of psychomotor activity, followed by increased interest in personal appearance, awareness of surroundings and gradual fade-out of delusions and hallucinations, and finally improved social performance. The patients who seemed to respond most favorably to fluphenazine were those schizophrenics in whom

fixed paranoid ideation evoked delusional acting-out behavior.

Two patients who responded very satisfactorily to the treatment and whose improvement seemed well stabilized over a period of six months, relapsed suddenly, with full reappearance of previous psychotic behavior. Some improvement was obtained in one of these patients when fluphenazine was increased up to 50 mg. per day while the other patient still presents the same psychotic picture found at the time this study was initiated.

These two relapses during the administration of the drug suggest that, in the investigation of psychopharmacological agents, the ability of phrenotropic compounds to sustain or restore improvement should be considered in the over-all evaluation of efficacy.

Heparin and hospitalization

It has been our strong impression that patients with a painful thrombotic process in the deep venous system of the lower extremities experience the fastest symptomatic relief with the intermittent intravenous use of heparin. Of course, it is difficult to assimilate unbiased data on this point in a retrospective study such as this. A more objective method of study would be to note the average number of days spent in the hospital by patients who are admitted to the hospital because of deep thrombophlebitis, and who have no other illnesses that might prolong the hospital course. We found 119 such patients who met these criteria, excluding those with a recent history of trauma and excluding 2 patients who signed out shortly after admission (Table 6). The shortest average hospital stay, six and eight-tenths days, was achieved in 5 patients treated by venous ligation. Of those managed with anticoagulants alone, the shortest average stay was achieved in the group treated intravenously with heparin, eleven and two-tenths days, and the longest average hospital stay in those treated with bishydroxycoumarin alone, twenty-eight and eight-tenths days. *Capt. Charles H. Fuller, USAF, et al. Management of Thromboembolic Disease. New England J. Med. Nov. 17, 1960.*

Treating Negro alcoholics

Particular features of the American Negro subculture, as reflected in patterns of interaction and conflict, were discussed in their possible relation to the development of patterns of excessive drinking and motivation for recovery. The Negro patients were seen to exhibit strong strivings for middle-class status and morality. Particular emphasis was given to the significance of the matriarchal organization of most Negro families. This legacy from the slavery period was seen as catalyzing the development of dependency patterns in the men with resulting conflict, tensions and pressures evocative of resort to excessive drinking; and as imposing added tensions and pressures on the women, with similar effect. The strong feeling of responsibility for maintaining the family, however, was seen as a highly favorable prognostic factor.

It is concluded that while the treatment of Negro alcoholics must be as individualized as that of white patients awareness of the special cultural forces and motivational elements involved, together with the avoidance of stereotypical thinking, can result in more effective therapeutic function. *Robert Strayer M.S.W. A Study of the Negro Alcoholic. Quart. J. Stud. Alcohol. March 1961.*

Simplified Health Insurance Claim Forms

Norman D. Steingraber, *Health Insurance Council*

Time physicians need to spend completing claim forms for health insurance has been a growing problem. The number of individuals covered by health insurance in the past decade has almost doubled. This coverage is provided by approximately 1,200 voluntary insuring organizations with numerous types of insurance claim forms.

Through the joint cooperation of the American Medical Association and the Health Insurance Council, a considerable amount of work has been done during the last six to eight years to help solve the problem. Efforts have been directed to simplifying and reducing the number of attending physicians forms to a degree equally acceptable to the health insurance industry and the medical profession.

This task was not easy. Information requested by many diverse forms from a large number of insurance companies was first classified, and minimum needs for claim purposes were determined. Then appropriate and clearly worded questions were developed and arranged in a standard sequence, to facilitate completion.

Out of this came two basic forms, one for group health insurance and one for individual health insurance, and four abbreviated forms. These were endorsed by the American Medical Association in 1955. The forms were, and still are, identified by code numbers as follows:

GD-1 Contains all questions normally needed to establish proof of loss under any group health insurance policy.

ID-1 Contains all the questions normally needed to establish proof of loss under any individual or family health insurance policy.

The four shorter supplementary forms for both group and individual coverage are:

GDS-1 This Attending Physicians Supplementary Statement is a variation of the GD-1 and was designed specifically for use as proof of continuing disability under group loss-of-income insurance.

GS-1 This Surgeon's Statement is also a variation of the GD-1 and was designed specifically for use with group surgical expense insurance.

IDS-1 This Attending Physicians Supplementary Statement is a variation of the ID-1 and was designed specifically for use as proof of continuing disability under individual loss-of-income insurance.

IPHS-1 Attending Physicians Statement for individual and family hospital or surgical expense insurance.

As the standardized program gained momentum, it became evident that doctors found it difficult to differentiate between the nonstandardized forms and those developed by the Health Insurance Council. To solve this problem, the Council, in addition to identifying the forms

with code numbers, developed the HIC symbol which could be imprinted on the standardized forms. The symbol cannot be used on forms that do not conform to stipulated specifications.

It should be noted here that some medical organizations and individual physicians endorsed the two basic forms (GD-1 and ID-1) and maintained supplies in their offices. At the same time many doctors expressed a preference for just one form that they could stock. The Health Insurance Council and the American Medical Association, in response to these requests and after months of negotiations, devised an all-purpose form which is a combination of the GD-1 and ID-1 forms. It can be identified by the code number COMB-1 and the HIC symbol.

The new COMB-1 form, does not, nor is it expected to, replace the existing HIC approved program of simplified claim forms now used by insurance companies. It was devised for individual doctors, clinics, and medical societies in lieu of unacceptable forms received from insurance companies. This is the form being distributed by the Illinois State Medical Society to each of its members with the request that it be substituted for any nonstandardized forms received.

We in the health insurance industry feel that excellent progress is being made to eliminate the multiplicity and complexity of claim forms. This should not be interpreted to mean that we have reached Utopia. The Uniform Forms Committee of the Health Insurance Council is constantly re-examining this program to see if improvements can be made. We sincerely hope that each doctor in Illinois will support the effort to gain universal acceptance and use of the standardized forms as identified by the HIC symbol.

On behalf of the Health Insurance Council, I sincerely thank the staff of the Illinois State Medical Society and the members of the Prepayment Plans and Organizations Committee for their time and effort in working with us.

Malpractice insurance

There will always be shades of difference among insurance carriers in the interpretation they place on standard professional policy provisions, but the standard medical professional liability policy appears not to reflect present-day conditions. It is antiquated. It is not surprising to find a widespread difference in opinion among the carriers as to whether there is coverage. Today it is not the charlatan or the marginal physician who is being sued for malpractice; it is the reputable physician. Hence the medical professional liability insurance policy should be re-examined and clarified in the light of modern medical practices. Representatives of medical societies should answer the physician's question concerning the extent of his coverage, and alert him to the exclusions and ambiguities which exist in his policy. At the same time insurance carriers should be encouraged to bring their policies up to date so that the physician will have the protection which he wants, which he needs, and which he thought he had. *William J. McAuliffe, Jr. Are You Covered? J. Kansas M. Soc. January, 1961.*

No test for schizophrenia

We are limited in our search for a biochemical test for schizophrenia by lack of knowledge concerning both the causes and the categories of the condition. Of course there is still hope that by more subtle biochemical techniques or new approaches we may be able to devise a test that will detect chemical changes occurring in all forms of schizophrenia, regardless of the etiologic differences, and not occurring in other diseases. All that we can say at this time is that the determination of serum ceruloplasmin is not such a test. *Ronald R. Koegler, M.D., et al. Wanted: A Biochemical Test for Schizophrenia. California Med., January, 1961.*

Rheumatoid hands

Often the earliest manifestations of rheumatoid arthritis in the hands is spasm of the intrinsic muscles. *Alfred B. Swanson, M.D. The Need for Early Treatment of the Rheumatoid Hand. J. Michigan M. Soc. March 1961.*

EDITORIALS



The married intern

The April issue of The New Physician contained an editorial plea for higher stipends for the hospital intern and resident. The suggestion was made to charge $1.00 per day per patient for routine house staff services. The money would be used exclusively to augment their meager pay.

We prefer to remain neutral on this argument because of the question as to where education ends and service begins. There are a few points germaine to the subject that should be mentioned at the risk of being labeled an old fuddy duddy.

Times have changed in that many medical students are married while in school, and some have a sizable family by graduation. The internship and residency are none too pleasant for those who are married, and the little woman has reason to squawk. In the first place, the usual hospital stipend is not "first-class take home pay" even for a family on relief. In the second place, the breadwinner is not on an eight hour, five day a week schedule, and, therefore, makes a poor family man.

Young people are not bothered by poverty so long as they can live on love. But they balk, and rightly so, when they have neither. But the older physician seldom sheds tears over the plight of his understudy. He went through school during an era when it was customary for a young man to delay marriage until he could support a wife. He controlled the urge to marry because he anticipated the road ahead; marriage was the second bridge to cross. The first was a thorough medical training. He had a goal, and seldom deviated.

But, as we have said, times have changed. There is a tendency to marry at a younger age, possibly because no one dares to admit he cannot cope with any situation that might arise. Never, since the days of Don Quixote, have so many young students bucked the windmill of love with so much confidence. At least Don Quixote had a horse and lance, which is more than we can say for the married intern. We admire their courage and determination, but when the ax falls or baby needs a new pair of shoes, it is hardly cricket to cry on the shoulders of the hospital superintendent and demand a higher stipend.

Suicide and psychologists

Two VA psychologists, co-directors of the Suicide Prevention Center in Los Angeles, believe that a wide campaign against suicide, similar to that against other leading causes of death, is necessary. In their opinion "there is confusion about the characteristics of suicidal behavior, and relatively little scientific research has been done on the problem of suicide." This we doubt unless suicide is regarded as a disease and not a symptom or manifestation of a disease.

The psychologists found many misconceptions in their study of suicide; many of these have been known for years. Depression may be a common cause of suicide, but it is not always present. The same applies to the mentally ill. Not all are disturbed emotionally or have character disorders. The jumping out of windows during the stock market crash of 1929 brought out this fact. The psychologists point out also that suicide is not limited to a special class of people. How true! In addition, it cannot be controlled by making it a crime. It is doubtful if the depressed victim cares what the law thinks. If we made it a crime, what would the penalty be for those who attempted but failed? A trial followed by a fine, jail sentence, or confinement in a mental insitution would add to rather than relieve burdens.

Suicide, in our opinion, is a psychiatric problem and beyond the realm of psychology. We

agree, however, that the causative factor should be recognized early in order to stop the potential victim from destroying himself.

On the other hand, the prevention of suicide on the highways is closer to psychology than medicine, and it is here that we need the benefit of the psychologists' training.

We are *physicians*

Members of the medical profession should be called physicians rather than doctors. There are more than 46 academic degrees and ranks that entitle their holders to refer to themselves as doctors. These include Doctors of Agriculture, Canon Law, Divinity Education, Fine Arts, Philosophy, and many others. But the list also includes many degrees in fields related to medicine, such as the Doctor of Science, Chiropody, Surgical Chiropody, Veterinary Medicine, Hygiene, Osteopathy, Napropathy, and others. Hereafter refer to us as physicians because a doctor could be anyone with legitimate postgraduate training or a graduate from any diploma mill.

Laboratory personnel needed

Physicians are in a unique position to help increase the ranks of qualified personnel in hospital and private laboratories in the State of Illinois. According to recent information, more than four positions are available for every person qualified as a medical technologist. We recommend that you suggest such a career to the young people who are now about to leave our high schools.

The Board of Registry of Medical Technologists is the only national qualifying agency for schools of training medical technologists recognized by the American Medical Association, the American College of Surgeons, the American Hospital Association, the Catholic Hospital Association, the College of American Pathologists, and the American Society of Clinical Pathologists. Federal civil service rating requirements in this field also parallel these registry requirements. Two years of college work with a major in science are prerequisite to a full year's training in an approved hospital. Beginning in 1962, three years of college work prior to the hospital training will be necessary. Many colleges offer a training program combined with an academic program leading to a Bachelor of Science degree and completion of the requirements for registration by examination under the Board of Registry of Medical Technologists.

The distinction between training for a medical technologist and that for a medical technician should be pointed out to prospective students. Although certificates may be similar, a Medical Technologist certificate represents the highest type of training while a medical technician is not as fully or as ethically trained.

Prospective students should write for further information to The Registry of Medical Technologists, Muncie, Ind. Or they may be advised to consult pathologists conducting approved schools in their vicinity. See Reference Sheet in this issue.

Paul A. Van Pernis, M.D.

Cholesterol levels and eating patterns

Do eating patterns influence the cholesterol level? Rats are nibblers by nature but develop definite metabolic changes when force-fed three meals a day. They accumulate twice as much body fats as rats allowed to nibble identical diets. Their body content of protein and water is reduced, and thyroid and tissue enzymatic activities diminish. The cholesterol levels go up in this group, especially when the cholesterol content of the diet is increased.

These experiments, conducted at Michael Reese Medical Center, indicate that different eating habits are accompanied by differences in the manner in which the body handles its daily load of calories. Man, unlike the rat, is a creature that consumes full spaced meals which, in the light of these experiments, may contribute to his avoirdupois, high blood cholesterol, and atherosclerosis. Would he do better to nibble like a rat and consume smaller meals at more frequent intervals?

Cohn[1] mentions several patients of his own and from the literature in which the serum cholesterol levels fell when they were changed from a three-times-a-day diet to a formula diet consumed six times a day. There was a definite elevation in thyroid activity in two individuals.

[1]*Cohn, Clarence: Meal Eating, Nibbling, and Body Metabolism. J. Am. Dietet. A.* 38:433 (*May*) 1961.

A diet was prepared at the Center, containing 2,500 calories that could be used for eight or more feedings daily. It required no refrigeration and was more adapted to the housewife than the breadwinner. This is understandable, because our present eating habits are influenced by convenience, custom, working conditions, habits, and togetherness.

It will be interesting to watch the development of this project because the results so far suggest that man reacts physiologically as do other species to these changes in eating patterns.

Treatment of narcotic addicts

In April we wrote to the Division of Narcotics Control of the State of Illinois asking if they had a list of inpatient and outpatient facilities in the state for narcotic addicts.

The following answer was received:

In answer to your inquiry about inpatient and outpatient facilities in the state for narcotic addicts, I wish to state that under the law no private hospital shall treat narcotic drug addiction unless such hospital has first obtained a letter of approval for such treatment from the Division of Narcotic Control, Springfield, Illinois. Any hospital which has been licensed by the Department of Public Welfare for the care, custody, treatment, detention, and training of mentally ill persons, mentally deficient persons, or persons in need of mental treatment under the "Mental Health Code" may apply to the Superintendent of the Division of Narcotic Control, Springfield, Illinois, for the treatment of narcotic drug addiction. The hospital will not be approved unless such hospital has facilities in which the patient is kept under restraint and control at all times, that is, the hospital can account for the presence of the patient every second of the day, and the practitioner in charge of the treatment shall be well acquainted with the medical treatment of narcotic drug addiction.

Every letter of approval shall be upon the following conditions: (1) that the treatment shall be administered in accordance with medical practice; (2) complete medical report of such treatment shall be sent to the Division after each fifteen days of treatment; and (3) the only patients treated shall be those who are sent to the hospital by the Superintendent or court; provided that, in emergency cases, other patients may be treated if the Superintendent is immediately notified of such treatment.

If a person voluntarily admits that he is addicted, the Attorney General or the State's Attorney may petition the court that such person is an addict as defined in the Act, and shall proceed under the Civil Practice Act. If the respondent is found to be an addict, then the Court shall appoint the Superintendent guardian of the person and such person shall stand committed to the custody of such guardian. The Superintendent, as guardian, shall keep safely the person so committed and such person has recovered and is released as herein provided. The Superintendent may place that ward in any facility in the Department of Public Welfare, upon the consent of the Director thereof, or Department of Public Safety, or Division or portion thereof or the Superintendent may, with the consent of the officer in charge thereof, place such addicts in any other state department or governmental agency, city or county department or governmental agency, federal hospital or private approved hospital for the care and treatment of such persons.

No person committed under this act shall be released until he has been committed and detained for a term of at least 90 days; provided that the Superintendent may, on medical advice, release such addict before he has been detained for 90 days.

If we can be of any further service to you, please do not hesitate to write this Division.

John C. Cross
Superintendent

Bias

Clinical investigation of the individual patient, like retrospective epidemiologic research, is plagued by the possibility of bias, both in the source of data and in the investigator. In empirical investigations every scientist worth his salt is aware that he is biased, and designs his study so that he is eliminated as a judge, and by adequate controls attempts to counter any bias in his data. In any event, if necessary, he will place the bias against his hypothesis. *Benjamin Pasamanick, M.D. and Hilda Knobloch, M.D. Brain Damage and Reproductive Casualty. 1959 Brain and Behavior Symposium. Am. J. Orthopsychiat. April 1960.*

AT THE EDITOR'S DESK



Artificial Hearts?

Dr. Charles K. Kirby, president of the American Association for Artificial Internal Organs, is of the opinion that diseased, defective, or damaged hearts will be replaced by artificial human hearts within a few years. He described the potential artificial heart as a fist-sized, round-cornered plastic box with four protruding clear plastic flexible tubes, each the approximate circumference of a thumb.

Those of us who heard the symposium on artificial organs at the Clinical Conference of the Chicago Medical Society have no doubt that the artificial heart is "closer than you think."

What's New

A combination incubator and embedding oven was introduced recently by Labline, Inc. The "Wall Cab," as it is called, is only 12 inches deep and is made to conserve valuable work space on the bench.

The Colson Corporation introduced a "free-hand" incubator, so named because it provides free access to premature babies without appreciable loss of oxygen, and insures against retrolental fibroplasia. It includes an automatic 40 per cent oxygen limit governed by a unique oxygen control valve, as well as a visible five-day water supply.

The Hollister Umbilical Cord-Clamp is now available in individual pre-sterilized packets. This lightweight, disposable nylon clamp is also available in unsterilized form for hospitals that prefer to autoclave it with the OB instrument pack.

International Narcotic Laws

An attempt is being made through the United Nations to formulate a single set of international laws regulating most of the important aspects of narcotics control, such as quotas and types of narcotics permitted for controlled use.

Fiscal Responsibility

It is frightening to hear one of our senators report:

"There is little doubt in my mind that Congress is losing effective control over Federal expenditures. We act upon appropriations in such a piecemeal fashion that there is no one point where we can say 'This much we will spend next year — and no more.' There is no point in the process where a member must stand up and be counted for, or against, fiscal responsibility and a balanced budget."

Emotional Response to Toxemia

According to PD's *Patterns of Disease,* 67 per cent of pregnant women who develop toxemia felt pity for themselves and women in general. These feelings were nonexistent among patients who did not develop this complication. This is understandable because most of us have no complaint so long as everything goes well.

The pregnant woman may have stronger feelings along this line because she is the one who makes the sacrifice. In the same survey, 77 per cent with toxemia felt guilt toward their unborn babies, 70 per cent associated pregnancy with deceit, shame, or sin, compared with 6 per cent and 7 per cent respectively among healthy patients. Among the latter 72 per cent considered

procreation synonymous with womanhood, and 87 per cent expressed willingness to cope with the responsibilities of pregnancy.

Yes — Again

While I was thumbing through news releases a familiar opening sentence caught my eye, "Each year, many parents become apprehensive as the polio season approaches." I caught myself muttering "not again," possibly because of the years spent following the fund-raising campaigns of the National Society.

Pfizer takes up where the society left off, tempered somewhat with the following sentence: "Fortunately, today their alarm is not what it was prior to 1955 when there were no weapons with which to fight the dread disease."

This is the opening gun for the Sabin type oral poliomyelitis vaccine—brace yourself men—here it comes.

Pharmaceuticals

Central Soya has a new anticholesterolemic product that is being presented exclusively to the medical profession. It is Soy Phosphatide. It has a ratio of unsaturated to saturated fatty acids of 6.7 to 1.

A news release was received recently from Pfizer, describing the use of Atarax among American Indians in labor. It was said to help shorten the time interval of labor in 235 expectant mothers in a New Mexico hospital.

The claim was based on the reasoning that many of the mothers were American Indians who had little or no previous prenatal care and consequently were nervous and upset on being admitted to the hospital. No toxic effects or adverse reactions were observed among the newborn babies.

Parnate is Smith, Kline & French's new prescription drug for the symptomatic treatment of mental depression. It is tranylcypromine, a potent monomine oxidase (MAO) inhibitor. It is not a hydrazine derivative.

It is claimed to relieve symptoms of mental depression, including dejection, self-depreciation, decreased activity, difficulty in making decisions, and disturbed eating and sleeping patterns. It is also said to aid psychotherapy by increasing the patient's willingness to exert mental effort and by reducing preoccupations.

WIN-18446 caused a complete arrest of spermatogenesis in rats. This study, being conducted at the Sterling-Winthrop Research Institute, plus a few human experiments is the beginning of a new birth control pill for men. For the scientifically curious we add, "The sex drive of the male rats was not noticeably affected."

Anadrol is Syntex Corporation's new anabolic hormone. This synthetic steroid was designed to be used primarily in the treatment of patients in whom solid weight gain is essential, or to halt tissue breakdown. The product is entering a field with considerable competition.

Eight Million Hot Dogs

We learned recently from "Glycerine Facts" that we Americans consume more than eight million hot dogs annually. The credit for making the wienie the most popular stuffed meat product goes to the development of artificial casings with a controlled stretch.

Animal intestines were used prior to 1926, but they could not be adapted to mass production because they were difficult to clean and varied in size and thickness. The modern meat casings are made from cellulose, glycerine, and water. They come in 1,100 varieties and retain their strength and elastic memory even when dry. Glycerine gives the casing flexibility, and its humectant properties prevent it from becoming stiff and brittle before use.

Automation Comes to Toothbrushes

Broxodent is Squibb's new electric toothbrush. The hand unit contains a small electric motor that moves the shaft up and down. The brushes are detachable so that several members of the family may use the device. The bristles are made of a special polyamide plastic with rounded ends which will not damage the gums nor scratch tooth enamel.

Squibb claims that it cleans teeth more rapidly and the small vibrating brush cleans every dental surface, including those hard-to-reach back teeth. Time will tell whether Broxodent is a gadget

or will enjoy the popularity of the electric shaver. It carries the Underwriters Laboratories' Seal of Approval.

More Poly-unsaturated Fat

Swift and Company reports that they have a new margarine with the highest percentage of poly-unsaturated vegetable oil of any table spread on the market. According to Dr. H. E. Robinson, Swift vice president and director of research, the new margarine (Award) contains two to five times more poly-unsaturated fat than regular margarine. No comparisons were made with other newer margarines containing high percentages of poly-unsaturated fats.

Improved Ankle Brace

A radical new leg and ankle brace was developed recently by the Biomechanics Research Group at the University of California. The appliance is not yet ready for production, but it is expected to revolutionize below-knee bracing because it permits all normal action of the ankle — including side-to-side and rotation motion. It should enable victims of polio, cerebral palsy, spina bifida, and other crippling conditions to walk with relative freedom. The study was financed by Easter Seal Funds.

Statistical Corner

The Metropolitan Life Insurance Company reports that homicide takes more than 8,000 lives a year in the United States. Over half the victims are slain by firearms, and about one out of four slayings are caused by cutting and piercing instruments.

The homicide rate among nonwhite males is over 10 times that for white males; in 1958, the latest year for which data are available, 34.7 nonwhite male homicides per 100,000 occurred as opposed to 3.4 among white males.

Relative frequency of homicide is highest in the South, lowest in the North; the West is in an intermediate position. In 1958 the rate ranged from 1.1 per 100,000 population in New England to 8.8 in the East South Central area. Five states—New Hampshire, Rhode Island, Massachusetts, North Dakota, and South Dakota—recorded homicide rates of less than 1.0 per 100,000, with New Hampshire having the lowest rate of 0.3. Three southern states had rates exceeding 10.0 per 100,000: Alabama, 11.4; Florida, 10.7; and Georgia, 10.4.

According to Illinois State News, a total of 88,029 marriages took place in Illinois during 1960. Divorces during 1960 numbered 21,652, which does not speak well for the stability of the Illinois family.

Quick Test for Hearing

Danavox is introducing a new "quick check" screening audiometer, which is said to be practical, inexpensive, and a reliable means of testing hearing quickly and accurately. It is the size of an apple and is completely transistorized and operates on one 2.8 volt battery which will last approximately a year.

There are three frequency settings: 250 c/s, 1000 c/s, and 4000 c/s. There are three db levels: 20, 40, and 60.

It is not designed to replace a clinical audiometer; it is a screening device.

Co-existence

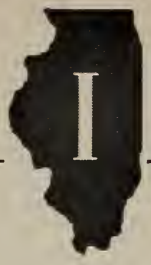
The Veterans Administration reports that a surprising number of patients with ankylosing spondylitis also have ulcerative colitis and regional ileitis. The arthritis may be a complication, although this is doubtful because the joint manifestations came first in a majority of cases.

Shark Contrast

The American Institute of Biological Sciences reports that sharks are less likely to attack swimmers in light colored suits. The contrast of a black suit on white skin is the attraction. If it is contrast that attracts, we might suggest that the color of the suit match the color of the skin.

A man to be truly free must accept responsibilities. To be relieved of responsibility means to lose freedom and liberty. Thus it can come about that the real enemy of man can be the state. — *C. T. A. Sparks, D.D.*

ANNOUNCEMENTS



PG courses

The 1961 postgraduate courses sponsored by the Council on Postgraduate Medical Education of the American College of Chest Physicians begins July 24-28 at the Brown Palace Hotel, Denver. It will deal with "Cardiopulmonary Problems in Children." Details on the remaining four courses will appear in later Journals.

Tuition to members of the ACCP is $75; to non-members $100. For more information write the American College of Chest Physicians, 112 E. Chestnut St., Chicago, 11.

Rocky Mountain Cancer Conference

The annual Rocky Mountain Cancer Conference is scheduled for July 12-13 at the Brown Palace West, Denver, and will feature two panel discussions, "Detect Cancer in Time! — Procedures, Problems and Solutions," and "Neoplasms of the Female Genital Tract." The presidents of the American Cancer Society and the American Medical Association will participate in the program, and Dr. Manuel E. Lichtenstein of Chicago will be one of the speakers.

Sessions will include panel discussions, round table luncheons, and individual papers. The conference is cosponsored by the Colorado Division of the American Cancer Society and the Colorado State Medical Society.

For further information write the Rocky Mountain Cancer Conference, 835 Republic Bldg., Denver 2.

Prize for medical research

The Institute of Medicine of Chicago is offering the Joseph A. Capps Prize for Medical Research, a biennial prize of $500, for the most meritorious investigation in medicine, specialties or in the fundamental sciences provided that the work has a definite bearing on some medical problem.

Competition for 1961 is open to graduates of Chicago medical schools who completed their internship or one year of laboratory work within a period of five years prior to Jan. 1, 1961, excluding their terms of service in the Armed Forces.

Manuscripts must be submitted to the Secretary of the Institute of Medicine of Chicago, 86 E. Randolph St., Chicago 1, not later than December 31, 1961.

The prize paper, as submitted, will become the property of the Institute of Medicine.

New Blue Shield program

Blue Shield Plans will offer an entirely new uniform program on a nationwide basis when a proposal adopted at the annual national meeting of the Blue Shield Association in Chicago in April is implemented.

The program will equip the organization to compete with full effectiveness for the first time in the enrollment of companies whose operations and employees are located in widely separated areas across the nation. Its most important aspect is the method developed to establish the payments for covered services to be provided. Benefit schedules will be adaptable to local administration and prevailing local costs in any number of Blue Shield Plans anywhere in the country.

The new nationwide program would be available in addition to existing Blue Shield offerings for local groups. In no way will it conflict with local plan operations. Instead, it would simply

extend the capability of individual plans to serve national accounts on a more competitive and realistic basis than is now possible.

Closed-circuit TV for meetings

CIBA Pharmaceutical Products, Inc. has joined Theatre Network Television, Inc. (TNT) in a two-year contract under which TNT will produce a series of medical closed-circuit telecasts sponsored by CIBA. The contract will include 10 telecasts of the meetings of various medical groups throughout the country. The first of these was a one-hour color telecast for the American Academy of General Practice at their annual meeting in Miami on April 19. A special TV remote unit was used to film the program, which was viewed by the physicians on a TV projector.

The meaning of "RT"

The American Registry of X-ray Technicians, headquartered in Minneapolis, is the sole organization offering certification or registration of x-ray technicians recognized by the American College of Radiology and the American Medical Association.

The Registry offers supervised examinations for a technician after he has followed a course of training approved by the AMA, the American College of Radiology, and the American Society of X-ray Technicians. These examinations are conducted by radiologists selected by the Registry, and after passing one, the technician is registered and authorized to place after his or her name the designation RT (ARXT), Registered Technician.

This signifies that the individual has successfully undertaken a given course of training, achieved a specific level in x-ray technique, adhered to a well-defined code of conduct, and passed a supervised examination.

Dr. Hammond Editor of New York Journal

Dr. William Hammond has been appointed editor of the New York State Journal of Medicine, official publication of the Medical Society of the State of New York. Assistant editor for the past three years, he succeeds the late Dr. Laurance D. Redway. The Journal is published twice monthly for the 26,000 physicians in the society, the third largest medical organization in the world.

Dr. Hammond, a native of New York City, now lives in Scarsdale. He received his degree in medicine from McGill University in Montreal in 1927 and, after hospital training there and in Boston, has practiced internal medicine in Westchester County since 1931.

He has been medical consultant to the Department of Family and Child Welfare of Westchester County for 20 years and consultant to the State Department of Social Welfare in its program for aid to the disabled for the past ten years. He is affiliated with Grasslands, White Plains, and St. Luke's Convalescent hospitals.

He is first vice-president of the American Geriatrics Society and has conducted research and published reports in the fields of geriatrics, welfare, and nutrition. Congratulations, Dr. Hammond.

Medicine on postage stamps

Recent issues of postage stamps of medical interest include the following:

Afghanistan — Two for the benefit of the Red Cross show an ambulance.

Angola — A 2½e issue shows the distribution of medicine.

Argentina — A four-value set includes medicinal plants.

Belgium — Six antituberculosis stamps feature arts and crafts.

Bolivia — Eight stamps in tribute to the Children's Hospital at La Paz, sponsored by the Rotary Club, show a nurse holding a child.

Central Africa Republic — A 20f stamp shows the Pasteur Institute at Banqui and an inset portrait of Pasteur.

Costa Rica — A St. Vincent de Paul commemorative set includes views of an old and a modern hospital.

Czechoslovakia — A six-value set includes medicinal plants.

Ecuador — Two Red Cross issues show the Red Cross headquarters building in Quito and an insert of Dunant, founder of the International Red Cross.

Finland — Three stamps carry a surcharge for the benefit of the Red Cross.

France — Two Red Cross stamps show saints and beggars.

Germany (East) — Three stamps to commemorate the 250th anniversary of the Charite Hospital of Berlin bear portraits and autographs of Rudolph Virchow, Robert Koch, and Wilhelm Griesinger.

Greenland — A stamp shows a drum dance, performed by Greenland medicine men for centuries to drive off evil spirits.

Guinea (Portuguese) — A 1½e stamp shows a traveling medical unit.

Hungary — Six health stamps, among other things, show a man on an operating table, an ambulance, and a hypodermic syringe. A 60f stamp pictures Dr. Ignaz Semmelweis.

Indonesia — Four stamps commemorating World Health Organization Day show an *anopheles* mosquito and bear the inscription: "Destroy Malaria."

Israel — A 25a stamp shows the new Hadassa Medical Center.

Jugoslavia — Mihailo Pupin (1854-1935), physician and electrical engineer, is shown on a new series honoring famous men of culture.

Korea (South) — A new stamp commemorates World Health Organization Day.

Pakistan — Two stamps commemorate the centennial of the King Edward Medical College, the country's oldest medical institution.

Russia — Three stamps honor N. V. Skilfosovsky, Russian surgeon; Robert Koch, German biologist, and N. Pirogov, Russian surgeon;

United Arab Republic (Egypt) — Two stamps honor World Health Organization Day.

Booklets for parents

A four-page leaflet, "Innocent Heart Murmurs in Children," has been issued by the Illinois Heart Association to help physicians quiet parents' alarm when told their children have innocent or functional heart murmurs.

In easily grasped lay terms it explains the difference between organic and innocent murmurs and why the family physician and/or heart specialist may wish to examine children with an innocent murmur more than once.

Copies for distribution to parents may be requested by physicians from local Heart Units or the Illinois Heart Association, 715 S. Sixth St., Springfield, Ill.

The National Society for Crippled Children and Adults has published "Growing Up—Cerebral Palsied Children Learn to Help Themselves," a new pamphlet designed to remove the mystery from cerebral palsy and enable children to live with it comfortably. The author is Mrs. Mildred Shriner, a teacher in Sunset School for physically handicapped children in San Lorenzo, Cal. She directed the first workshop in cerebral palsy for teachers at the University of California and conducted similar sessions at Teachers College, Columbia University.

Her booklet describes practical means for the child to achieve mastery over everyday tasks like eating and dressing and advises parents how to maintain proper, healthy attitudes toward their children.

Copies are available through the National Society for Crippled Children and Adults, 2023 W. Ogden Ave., Chicago 12, at 25 cents each.

Crippled children's clinics for July

July 1 Chicago Heights Cardiac, St. James Hospital
July 6 Hinsdale, Hinsdale Sanitarium
July 7 Flora, Clay County Hospital
July 12 East St. Louis, St. Mary's Hospital
July 12 Peoria, Children's Hospital
July 13 Champaign-Urbana, McKinley Hospital
July 13 Joliet, Silver Cross Hospital
July 14 Cairo, Public Health Building
July 14 Sterling, Community General Hospital
July 14 Springfield, St. John's Hospital
July 19 Alton, Alton Memorial Hospital
July 19 Danville, Lake View Hospital
July 19 Quincy, St. Mary's Hospital
July 20 Evergreen Park, Little Company of Mary Hospital
July 21 Elmhurst Cardiac, Memorial Hospital of DuPage County
July 21 Rockford, St. Anthony's Hospital
July 26 Effingham (Rheumatic Fever), St. Anthony's Hospital
July 26 Peoria, Children's Hospital
July 27 Aurora, Copley Memorial Hospital
July 27 Springfield P.M. (Cerebral Palsy), Memorial Hospital
July 28 Decatur, Decatur-Macon County Hospital
July 28 Mt. Vernon, Masonic Temple



Miranti Photo

Edwin S. Hamilton, M.D., President
Illinois State Medical Society
1961-1962



Members of the House of Delegates began transacting the business of the annual meeting on Sunday, May 14.

Annual Meeting Highlights

Hamilton installed as president

Dr. Edwin S. Hamilton of Kankakee, a prominent figure in international medicine and a founding member of the World Medical Association, was installed as president of the Illinois State Medical Society on May 18 in closing ceremonies of the annual meeting. He succeeds Dr. H. Close Hesseltine of Chicago.

Dr. Hamilton was a member of the Council of the Illinois State Medical Society for 27 years, longer than any other member, and is immediate past president of the Kankakee County Medical Society.

He served on the boards of trustees of the AMA for 10 years and for the WMA for six years. He was secretary of the board of trustees of the AMA for nine years and chairman for one year.

Born in Emington, Ill. in 1890, he graduated from Kankakee High School and went on to receive his A.B. degree from the University of Illinois in 1911. In 1912 he obtained his B.S. from the University of Chicago and in 1913 his M.D. from the Rush Medical College. He interned at Cook County Hospital for two years and was a captain in the Army Medical Corps overseas in World War I.

He has been chairman of the Interstate Postgraduate Medical Association for the past six years and a trustee since 1942. He is a member of the International College of Surgeons, the Illinois Surgical Society, and the New York Central Railroad Surgeons.

Long an indefatigable worker in the civic affairs of Kankakee, Dr. Hamilton is a member and past director of its Chamber of Commerce, vice president and director of the City National Bank there, president and director of the Kankakee Title and Trust Company, and a director of the Kankakee Hotel. He is a past director of the Kiwanis Club and a member of the Kankakee Country Club and the Chicago Athletic Association. He is a past trustee of the Elks, past commander of the American Legion, a Mason and Shriner, and a member of the Veterans of Foreign Wars.

Lull chosen president elect

Dr. George F. Lull of Chicago, medical director of the Cook County Public Aid Department since June 1960, was chosen president elect at the annual meeting of the Illinois State Medical Society.

Dr. Lull has a wealth of administrative experience—16 years—in organized medicine. He joined the American Medical Association in January 1946 as secretary and general manager, and was made assistant to the president in 1958 before his retirement from the AMA Jan. 1, 1959. The following October until June 1960 he served as temporary secretary-treasurer of the ISMS while steps were being taken to reorganize the Society.

"Although I have not been active as an officer in organized medicine for a few months," Dr.

(*continued on page* 420)

Honors and Awards



At the annual banquet, Dr. H. Close Hesseltine receives the Society's Certificate of Appreciation from Dr. Jacob E. Reisch, secretary-treasurer, for his devotion to duty as president.



Dr. E. A. Piszczek was praised for time and talent he gave to his office as chairman of the Council during the year. Dr. James H. Hutton, able master of ceremonies at the banquet, listened attentively as Dr. Hesseltine read the citation.

Checks totaling $141,650 were presented to the deans of the state's five medical schools at the opening meeting of the House. Left to right, Dr. Andrew H. Ryan of the Chicago Medical School, $25,879; Dr. John F. Sheehan, Stritch School of Medicine of Loyola University, $26,475; Dr. Robert G. Page, assistant dean, University of Chicago School of Medicine, $20,571; Dr. Granville Bennett, University of Illinois College of Medicine, $32,988; and Dr. Richard H. Young, Northwestern University Medical School, $35,737. Dr. George F. Lull, as president of the American Medical Education Foundation, and Dr. Arkell M. Vaughan, state chairman, made the presentations.

The funds are for unrestricted use except that they be considered over and above the budgeted program of the school. Dr. Young pointed out that the check for Northwestern represented income from more than an $800,000 endowment. All the deans expressed appreciation of the "fluid funds."





Honorary delegates and alternates from the Student AMA introduced at the opening meeting are left to right: Stritch, Joseph DeFiore and John Belmonte (alternate); Northwestern, Miss Sandra Jane Forbes; University of Chicago, Robert Ridley; Chicago Medical School, Laurence Seigler. John R. Shepherd, University of Illinois, was absent.



Mrs. Charles L. Wunsch, Aurora, retiring president of the Woman's Auxiliary (left) presents the gavel to Mrs. Richard E. Westland, Skokie (right) the newly elected president, while Mrs. W. J. Wanninger, Chicago, looks on.

One of the tables of councilors who met each morning at eight for breakfast. Shown left to right around the table are Drs. J. Ernest Breed, William E. Adams, Ted LeBoy, John L. Reichert, Leo P. A. Sweeney, and Bernard Klien. In the background left to right are Drs. Newton DuPuy, Percy E. Hopkins, and Burtis E. Montgomery. Drs. Sweeney and Hopkins are past presidents.



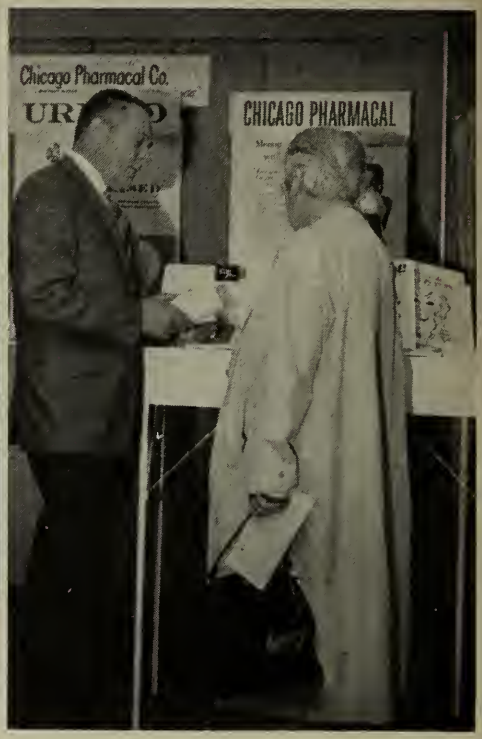
Illinois Technical Exhibitors



A. R. Schmechel of Chicago told our photographer he made his first purchase from V. Mueller in 1918.



A first day visitor, J. E. Gustafson of Stockton, Illinois, discusses new products at the Searle booth.



Johanna Heuman of Chicago paused to discuss Chicago Pharmacal products with their representative.



Abbott Laboratories (right) reported excellent attendance. Continental Medical Electronics (below) was a first-time exhibitor.

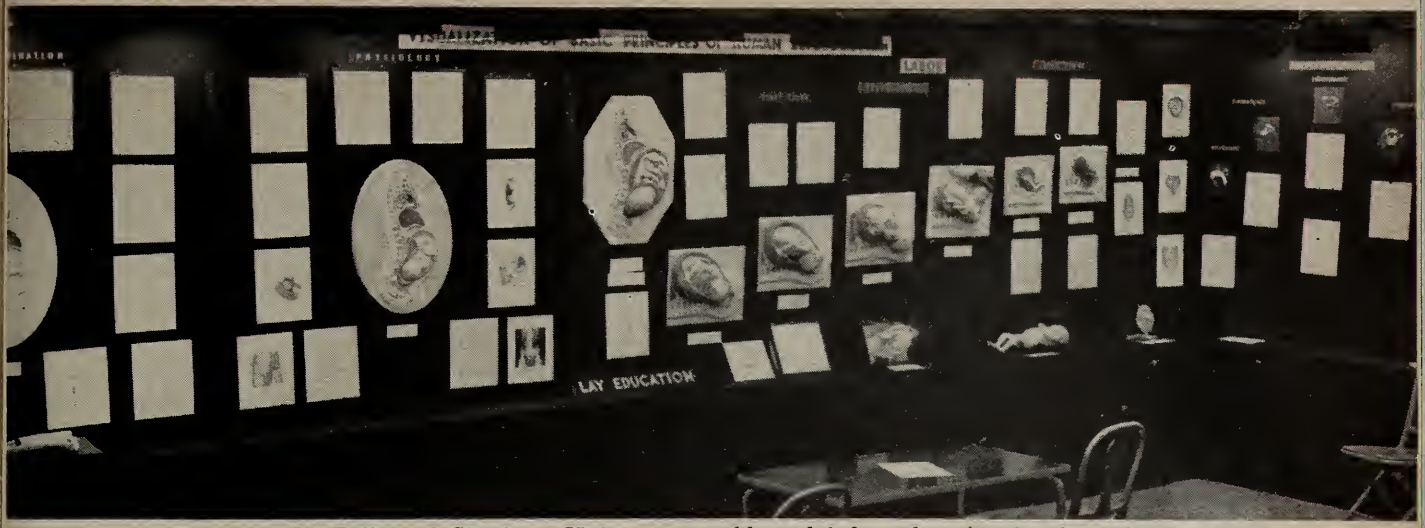
From opening time at noon on Monday, until closing Thursday afternoon, there were 3,015 registered for the meeting. Many of these visited the technical exhibits, the largest crowd appearing on Wednesday afternoon.



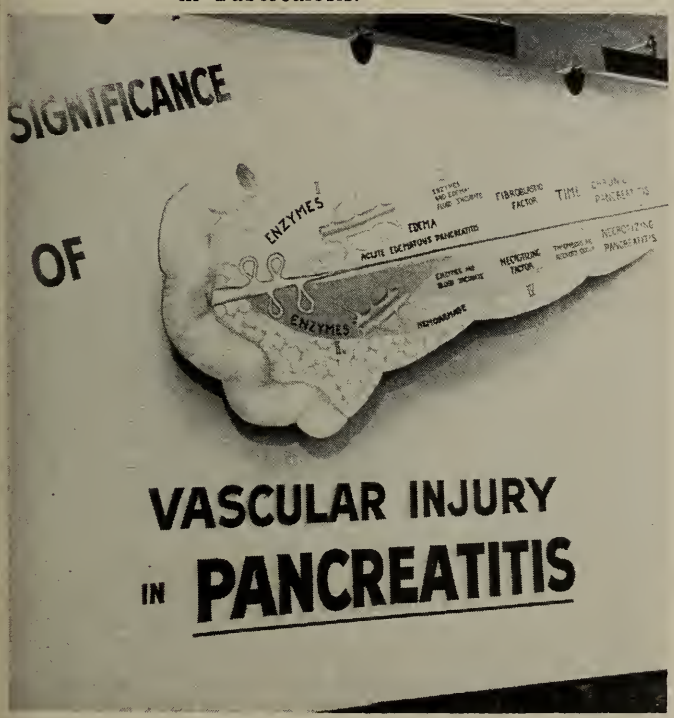
Dr. and Mrs. R. T. Matlavish of Duquoin visited the Daniels extensive exhibit of equipment. Dr. Matlavish was a delegate to the meeting.

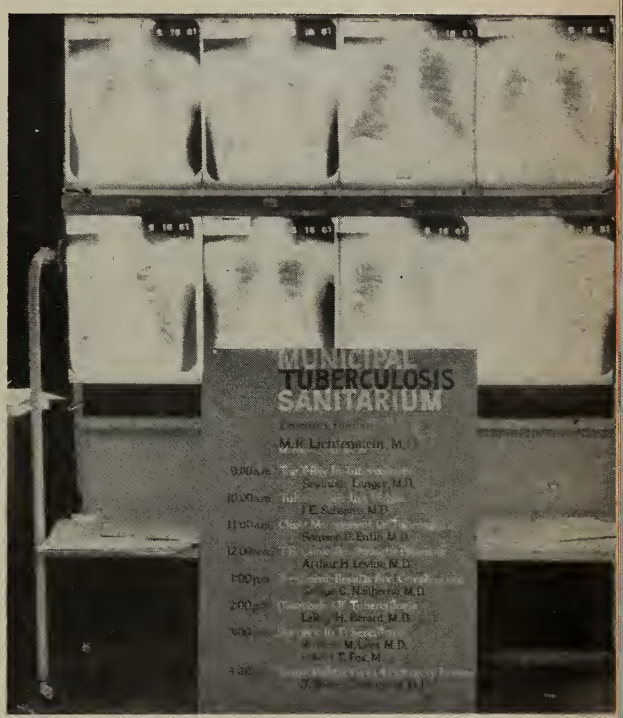


Medal-Winning Scientific Exhibits

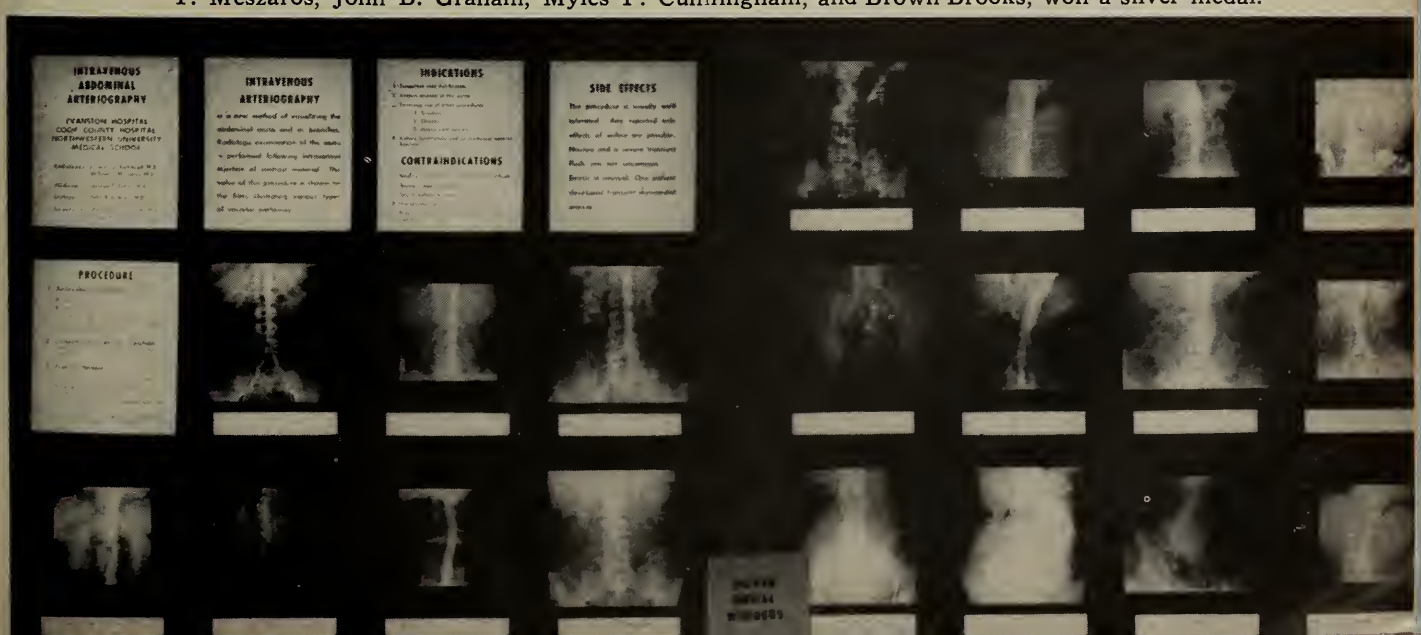


Frederick H. Falls and Charlotte Holt won a gold medal for educational value with "Visualization of Basic Principles of Human Reproduction." The exhibit "Significance of Vascular Injury on Pancreatitis; New Concepts of Pathogenesis," by Marion C. Anderson, John J. Bergan, and Phillip Wright, also won a gold medal. A silver medal went to Karl H. Pfuetze, George E. Turner, Meyer Lichtenstein, and Edward A. Piszczek, for "X-Ray Clinical Cases in Tuberculosis."





"Intravenous Abdominal Arteriography", by Howard C. Burkhead, George C. Sutton, William T. Meszaros, John B. Graham, Myles P. Cunningham, and Brown Brooks, won a silver medal.





Fabian Bachrach Photo

George F. Lull, M.D., President Elect

Lull said,"I have sustained my interest in it and will try to do the best job possible over the next two years. I realize these are important years to the membership of the Illinois State Medical Society and that it is imperative we present a united front against socializing influences."

Dr. Lull has had a distinguished career in medicine and in the Army. He received his M.D. degree from Jefferson Medical College, Philadelphia, in 1909. Subsequently, he received other degrees: Master of Public Health, Harvard, 1921; Doctor of Public Health, University of Pennsylvania, 1922; Doctor of Laws (Hon.), Jefferson Medical College, 1943; Doctor of Science (Hon.), Woman's Medical College of Pennsylvania, 1953.

He entered the Army in 1912 as a first lieutenant in the medical corps and retired in 1945 as a major general. In the interval, he saw service in various parts of the world. The last two years, he was deputy surgeon general of the Army.

His outstanding military service has brought him numerous honors, the Purple Heart in World War I, and in World War II the Distinguished Service Medal. He was given the Legion of Honor medal by France in 1940 and Cuba's Carlos Finlay Order of Merit medal in 1951.

Dr. Lull is a member of a great many organizations concerned with medicine.

He and his wife, Mildred, live at 942 North Lake Shore Drive.

Annual meeting attendance

Total registration for the 1961 Illinois State Medical Society's annual meeting reached 3,015, somewhat under 1960's record attendance at the Sherman Hotel of 3,387. The number of physicians attending was approximately a hundred less than the three year average. Guests, including interns, medical students, nurses, and wives of physicians numbered 508; exhibitors personnel, 351; and 404 members of the Woman's Auxiliary were present. Physician registration for Monday and Tuesday was 1,104 and on Wednesday increased by 408.

House elects officers

The House of Delegates of the ISMS voted on May 18 to create the positions of presiding and assistant presiding officers and selected Dr. Walter Bornemeier, Chicago, and Dr. Harlan English, Danville, respectively, for the posts. It was felt that this would enable the president to participate more freely in the overall planning of the meeting and give him more opportunity to greet guests and view the exhibits.

Dr. William Whiting, Anna, was elected first vice president and Dr. Eugene T. McEnery, Chicago, second vice president at the meeting. Dr. Jacob E. Reisch, Springfield, was re-elected secretary-treasurer, and Dr. Edward A. Piszczek, Chicago, was re-elected chairman of the Council. Councilors (all re-elected) are Drs. William E. Adams and John L. Reichert, Chicago; Fred C. Endres, Peoria Heights; Jacob E. Reisch, Springfield; Arthur F. Goodyear, Decatur; and Harlan English, Danville.

Re-elected as delegates to the American Medical Association are Drs. H. Kenneth Scatliff, Walter C. Bornemeier, and Frank H. Fowler, Chicago; Arthur F. Goodyear, Decatur; and Harlan English, Danville. Dr. E. W. Cannady of East St. Louis was elected to replace Dr. Joseph T. O'Neill, deceased.

The re-elected alternate delegates are Drs. Eugene T. McEnery, George C. Turner, Edward A. Piszczek, Chicago; and Jacob E. Reisch, Springfield. Also elected were Newton DuPuy of Quincy and Carl E. Clark of Sycamore.

Committeemen of the House of Delegates elected to serve during 1961-1962 are as follows:

Grievance Committee—Drs. Arkell M. Vaughn of Chicago and Willis I. Lewis of Herrin, both re-elected.

Medical Benevolence Committee—Dr. Keith H. Frankhauser, Avon.

Medical Education and Hospitals Committee—Drs. Kenneth C. Johnston and George F. O'Brien of Chicago and Ward Eastman of Peoria, all re-elected.

Medico-Legal Committee—Drs. Leo P. A. Sweeney of Chicago and F. E. Bihss of East St. Louis, both re-elected.

Medical Testimony Committee—Dr. Joseph F. O'Malley, Chicago, re-elected, and Drs. L. F. Rickey, Freeport, and Allison L. Burdick, Chicago.

Prepayment Plans and Organizations Committee—Dr. Harry E. Mantz of Alton, re-elected.

NEWS of the STATE

Cook

Top Scorers. University of Illinois 1960 College of Nursing graduates scored highest in three categories and finished second in the remaining two of the five-part State Board examinations. The exams are given to all graduates of Illinois' 72 nursing schools and confer the title of Registered Nurse.

The graduates ranked highest in the areas of medical, surgical, and psychiatric nursing and second in obstetric and pediatric nursing.

Dr. Wright Returns to Research. Dr. F. Howell Wright, professor of pediatrics at the University of Chicago, is returning to research, clinical work, and teaching after serving for 15 years as chairman of the department of pediatrics. He will continue to serve as professor of pediatrics.

In 1940 he came to the university as an assistant professor of pediatrics and was appointed an associate professor in 1944 and professor in 1952. His successor has not yet been appointed.

Memorial Lecture. Lorenz E. Zimmerman, M.D. gave the fifth Edward Lorenzo Holmes Memorial Lecture of the Institute of Medicine of Chicago on May 20. He is chief of the Ophthalmic Pathology Branch and Registrar, Registry of Ophthalmic Pathology, Armed Forces Institute of Pathology, Washington, D.C. He spoke on "Acid Mucopolysaccharides in Ocular Histology and Pathology" at the meeting jointly held with the Chicago Ophthalmological Society.

Anniversary. The Institute for Psychosomatic and Psychiatric Research and Training held the tenth anniversary celebration of its opening May 3-4 at Michael Reese Hospital. Dr. Lawrence S. Kubie, director of training at the Sheppard and Enoch Pratt Hospital, Towson, Md., gave the annual Lasker Lecture on Psychiatry entitled, "The Struggle between the Eagle and the Ostrich."

Appointments

Dr. Friedrich Deinhardt has been named chairman of the department of microbiology, a newly created post at Presbyterian-St. Luke's Hospital. A graduate of the University of Hamburg, Germany, he came to the United States in 1954. He was formerly on the research staff of Children's Hospital, Philadelphia.

Dr. Lawrence Z. Freedman was appointed to a new professorship to head an intensive psychiatric study of non-conformist behavior to be conducted by the University of Chicago. He is a fellow at the Center for Advanced Study in the Behavioral Sciences at Stanford University and a former clinical professor in the department of psychiatry and visiting lecturer in the Law School of Yale University.

He will arrive in Chicago this summer to assume his new post as the first Foundations' Fund for Research professor of psychiatry, established by a $250,000 grant.

The National Institutes of Health, Bethesda, Md., has chosen Dr. Leslie B. Arey, professor emeritus at Northwestern University Medical School, as an advisor to its Laboratory of Perinatal Physiology of San Juan, Puerto Rico.

He retired in 1956 as chairman of Northwestern's department of anatomy but has continued teaching and doing research. He is president of the Chicago Academy of Sciences and a former president of the American Association of Anatomists.

Dr. Laurence M. Hursch, Washington, D.C., has been made a member of the Board of Trustees of the University of Chicago's Health Service staff in charge of environmental medicine. His appointment will begin September 1 following his retirement as colonel from the U.S. Army Medical Corps. He is now chief of the medical research branch of the U.S. Army Medical Research and Development Command.

He succeeds Dr. Leroy L. Fatherree, who resigned last year to become director of the Illinois State Board of Public Health.

Dr. Caesar Portes will become the medical director of the new Gottlieb Memorial Hospital, Leyden Township. The 122-bed, nonsectarian hospital, scheduled for completion in early summer, will serve the west suburban area. Dr. Portes was the chairman of the medical credentials committee which recommended appointment of the 135 physicians and surgeons now on the medical staff at the hospital. He also has been working with the administrative staff in planning the medical facilities.

Forest Hospital, Des Plaines, has appointed the following psychiatrists to its staff: Drs. Jay G. Hirsch, Victor J. Mintek, and Harold E. Stoner.

General

ACOG installs new Fellows

The American College of Obstetricians and Gynecologists inducted 473 new Fellows at the tenth anniversary meeting April 20-28 in Bal Harbour, Fla.

Grants

The Illinois Department of Public Welfare received $146,017 for work in connection with the site development at the Illinois State Pediatric Institute in the Medical Center in Chicago. The money, released from the State Mental Health Fund, is divided into general work, $92,500; plumbing, $18,872; electrical, $12,045; and landscape, $22,600.

The Children's Memorial Hospital, Chicago, has received a grant of $70,000 for research in mental retardation from the Joseph P. Kennedy, Jr. Foundation. This is an addition to a contribution made in 1959 and will be used to continue vital research in mental retardation under the leadership of Dr. Jerome L. Schulman, director of the Child Guidance and Child Development Clinic.

The Kennedy Foundation was established 15 years ago by Joseph P. Kennedy, former ambassador to Great Britain, in memory of his son, who was killed in action in World War II.

The Ford Foundation has made an $140,000 appropriation to be administered by the National Council on Aging. The funds will be used over a three year period to explore the need and nature of an organization for nonprofit homes for the aged, what form it should take, and what services it should perform. Also included in the project is preparation of a national directory of nonprofit homes for the aged.

Awards

James E. Stuart, president of the Blue Cross Association, has been selected to receive the American Hospital Association's 1961 Justin Ford Kimball Award. The award, named for the founder of the Blue Cross movement, will be presented at the Association's September meeting in Atlantic City. Mr. Stuart has been president of the Blue Cross Association since January 1, 1960, and before that was executive vice president of the Blue Cross Association.

Wabash General Hospital in Mt. Carmel won a first place plaque in the less than 100 employees category in the Hospital Safety Contest

sponsored by the American Hospital Association and the National Safety Council.

Among the winners of the Lakeside Awards for outstanding scientific exhibits was Constantine J. Tatooles, Loyola's Stritch School of Medicine. His exhibit was on "Coronary Occlusion, Acute and Chronic Manifestations."

The awards were initiated to stimulate interest in the use of scientific exhibits to communicate important information to students, educators, and medical practitioners.

The judges were H. Close Hesseltine, M.D.; Charles H. Bramlitt, M.D.; and Edwin R. Levine, M.D.

Seymour Benzer, professor of biophysics at Purdue University, was the 1961 recipient of the University of Chicago's Howard Taylor Ricketts Memorial Award. He delivered an address on "Genetic Fine Structure" at the University on May 17. He entered the departments of physics and biology at Purdue University in 1952.

Dr. Charles Huggins, director of the Ben May Laboratory for Cancer Research of the University of Chicago, was given the Order of the Sun, Class Grand Officer, the highest honor of the Peruvian government, in Lima recently. Dr. Huggins has been a professor at the university since 1937 and director of the Ben May Laboratory since 1951. He is an honorary fellow of the Royal College of Surgeons, Edinburgh and London, and a member of the National Academy of Sciences.

Tax revenue sources

The $3.1 billion budget presented by Governor Otto Kerner to the Illinois General Assembly will necessitate increases in some taxes plus added new taxes. According to figures from the Illinois Chamber of Commerce anticipated funds from present major tax sources are as follows:

Sales and use taxes—$780 million
Cigarettes—$56 million
Public Utilities—$97 million
Corporation Franchise—$12 million
Inheritance taxes—$50 million
Insurance—$57 million
Other sources—$45 million

Anticipated funds from new taxes or tax increases are:

Broadening base of sales, use tax—$153 million
Half-cent sales, use taxes—$119 million
Corporations—$60 million
Penny-a-pack on cigarettes—$28 million
Penny-a-cigar—$6 million
Hotel, motel tax of 5 per cent—$12 million

Major expenses of the state, as computed by the Governor, are:

Public assistance—$486 million
State aid for schools—$391 million
Highways—$325 million (Federal Government pays another $584 million)
State universities—$243 million
Welfare institutions—$218 million
Building construction—$78 million
Retiring building bond issues—$54 million

Deaths

Thomas G. Allin, Jr.*, Park Ridge, a graduate of the University of Wisconsin Medical School in 1949, died April 3, aged 36. He was medical director of Gillette Laboratories, a Chicago pharmaceutical company.

Joseph M. Burger, retired, Marion, a graduate of the Northwestern University Medical School in 1931, died March 19, aged 56. He was chief of surgical services at the VA Hospital in Marion until his retirement in 1957. He served in various military hospitals before going to the VA Hospital in 1948 and practiced in Hampton, Iowa, and Port Washington, Wis., before entering military service in 1942. He was a major in the Army Reserve.

Caroline Eaton, Cambridge, a graduate of the Hahnemann Medical College in 1904, died April 6, aged 89. She had practiced in Cambridge for 51 years and was a charter member of the local D.A.R.

Waldemar Eberhardt, retired, Chicago, a graduate of the Northwestern University Medical School in 1897, died March 31, aged 88. He had taught at Rush Medical School, now the Chicago Medical School, and at the University of Illinois Medical School and had practiced in Chicago from 1897 until he retired ten years ago.

Charles H. Eldridge*, West Frankfort, a graduate of the University of Louisville School of Medicine in 1910, died March 30, aged 78. He was the West Frankfort city health officer

and had practiced there for 45 years. He was also on the staff at Franklin Hospital, Benton, and Union Hospital, West Frankfort. He was a member of the 50-Year Club of the Illinois State Medical Society and received a 50-year pin from the Masonic Lodge in 1957.

Hugh A. Flack*, Chicago, a graduate of the Northwestern University Medical School in 1943, died April 3, aged 41. He was a staff physician at Passavant Hospital, an associate professor of internal medicine at Northwestern University, and a fellow of the American College of Physicians.

Ray M. Fouts, La Grange, a graduate of the University of Illinois College of Medicine in 1911, died September 15, aged 73. He was a veteran of World War I.

Samuel T. Glasford, retired, Pekin, a graduate of Barnes Medical College, St. Louis, in 1902, died September 17, aged 79. He was a member of the American Academy of Ophthalmology and Otolaryngology. In 1915 he did postgraduate work on the eye, ear, nose, and throat at Tulane University, New Orleans, and began practicing his specialty in Pekin upon completion of his studies, remaining there until his retirement.

William Hepburn, Ringwood, a graduate of the Memphis Hospital Medical College in 1899, died March 26, aged 87.

Onis H. Horrall, Chicago, a graduate of Rush Medical College in 1920, died April 1, aged 72. He was for 32 years the chief surgeon of the Chicago Burlington and Quincy Railroad and was surgeon for the American Bus Lines and the Valier Coal Company. He was also a consultant for the Union Pacific railroad and a fellow of the American Medical Association. He had served on the staffs of Boston, West Frankfort, and Du Quoin (Ill.) hospitals.

Edward W. Johannes*, retired, Dunedin Isles, Fla., a graduate of the Chicago College of Medicine and Surgery in 1908, died April 9, aged 75. He was a Chicago physician for many years before retiring 9 years ago. He had been a staff member of St. Mary of Nazareth Hospital and an Army Medical Officer in World War I.

William F. Lauten*, Chicago, a graduate of the University of Illinois College of Medicine in 1928, died April 6, aged 69. He was a staff member of Alexian Brothers and Grant hospitals, Chicago, and St. Charles Hospital, Aurora. He had recently been appointed health officer of Downers Grove and was emergency surgeon of the Wheaton Fire Department.

Waldo J. Lehman*, Chicago, a graduate of the Northwestern University Medical School in 1943, died March 17, aged 44. He was an orthopedic surgeon on the staff of Alexian Brothers Hospital.

Frank N. McLaren*, retired, White Hall, a graduate of Eclectic Medical College, Cincinnati, in 1904, died March 25, aged 81. He had practiced in White Hall for 51 years before retiring in 1959.

Lars S. Pederson*, Manhattan, a graduate of the Chicago College of Medicine and Surgery in 1913, died November 12, aged 79. He was associated with St. Joseph's and Silver Cross hospitals in Joliet.

Isaac H. Rosenberg*, Chicago, a graduate of the Chicago Medical School in 1930, died April 14, aged 61. He was on the staff at American Hospital for 25 years and was president of Congregation Beth Hillel V'Nachalath Mosheh.

Herman Rothert*, Carthage, a graduate of the Miami Medical College, Cincinnati, in 1897, died December 15, aged 85.

Claude J. Sanders*, Centralia, a graduate of the St. Louis University School of Medicine in 1906, died April 12, aged 78. He was president of the Ashley Township high school board for 13 years, a past president of the Ashley State Bank, and more recently served as a director of the City National Bank. He had been president of the Marion and Washington county medical associations and was a member of the 50-Year Club of the Illinois State Medical Society. He was a 32nd Degree Mason, a Shriner, and a Rotarian.

Herman L. Schaefer*, West Salem, a graduate of Northwestern University Medical School in 1891, died March 29, aged 92. He had practiced in West Salem for 65 years and had been surgeon for the Illinois Central Railroad for many years. He was an emeritus member of the Illinois State Medical Society.

Charles W. Stigman*, Chicago, a graduate of the University of Illinois College of Medicine in 1913, died April 20, aged 77. He was an attending staff member at Swedish Covenant Hospital.

**Indicates member of Illinois State Medical Society.*

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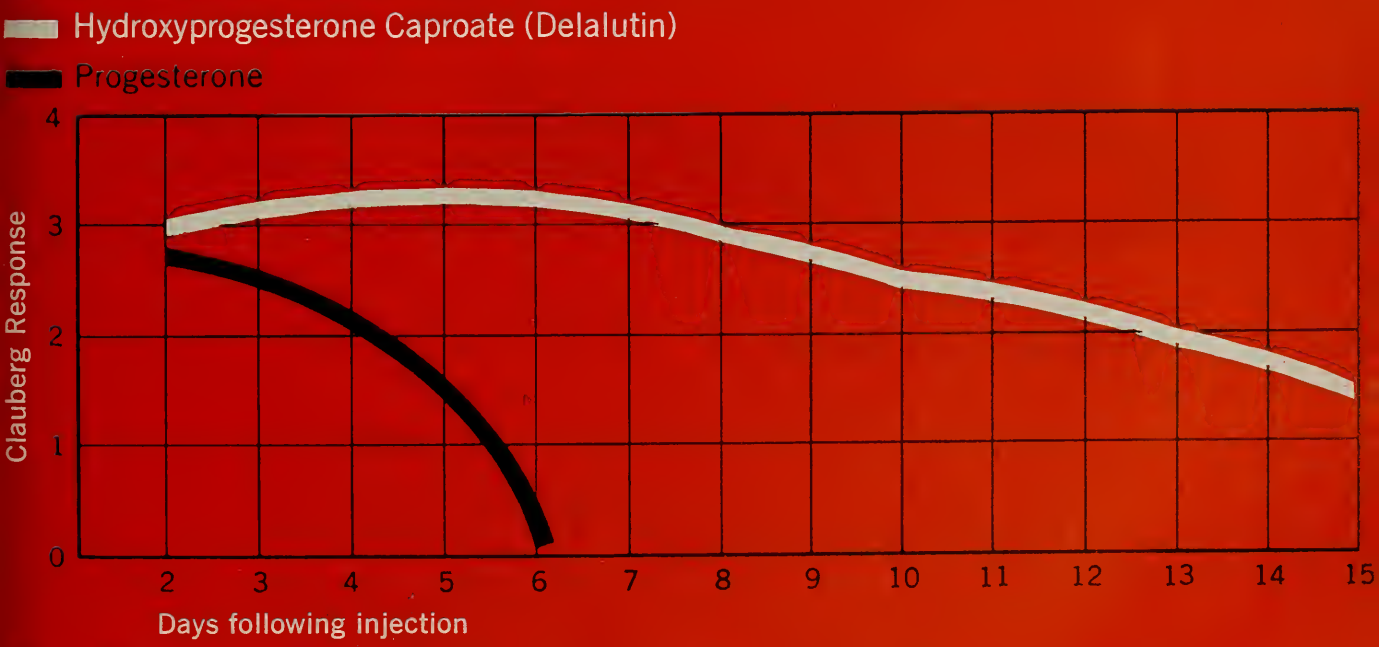
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Dorman, A: Laboratory Report on the Duration of Action of 17-Alpha-Hydroxy-progesterone-n-Caproate (Delalutin). The Squibb Institute for Medical Research, May 17, 1955.



Supply: Vials of 2 and 10 cc., each cc. containing 125 mg. of hydroxyprogesterone caproate in sesame oil with 35% benzyl benzoate. Vials of 5 cc., each cc. containing 250 mg. of hydroxyprogesterone caproate in castor oil with 61% benzyl benzoate. **References:** 1. Boschann, H. W., Ann. New York Acad. Sc. 71:727 (July 30) 1958. 2. Reifenstein, E. C., Jr.: Ann. New York Acad. Sc. 71:762 (July 30) 1958. 3. Castelazo Ayala, L., et al.: Gin. y Obstet. de Mexico 14:249 (May-June) 1959. 4. Plotz, E. J.: Abortion (Hemorrhage of Early Pregnancy), in Conn, H. F.: Current Therapy — 1960, Philadelphia: W. B. Saunders Co., 1960, pp. 613 ff. 5. Wright, H. L., Withers, R. W., and Ingram, J. M.: Am. Pract. & Digest Treat. 10:1544 (Sept.) 1959.

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Duration of reserpine effects

This study indicates that more than five weeks must be allowed after the cessation of reserpine therapy in human beings for all drug effects to be considered absent. With a single large dose of reserpine, blood serotonin had returned to normal in five weeks, and pupil size in seven days. Five weeks after the first dose, a second dose of reserpine resulted in a five-week period necessary for recovery of values of both blood serotonin and pupil size. In man, the action of a single large dose of resperpine seems to persist for one or two days (in terms of bodily discomfort and tranquilization), seven days (in terms of miosis) and four or five weeks (for blood serotonin values). Man, as compared to animals, seems markedly sensitive to both the blood and the central-nervous-system effects of reserpine. For a central-nervous-system-mediated response — miosis a "sensitizing" or latent effect of the first dose of reserpine upon the effects of a second dose is described. The importance of the interval between administering reserpine and measuring its effects in both clinical and laboratory studies is emphasized. An action of reserpine on megakaryocytes or precursors and a "sensitizing" action on brain amine mechanisms are suggested. *Daniel X. Freedman, M.D. and Arnold J. Benton, M.D. Persisting Effects of Reserpine in Man. New England J. Med. March 16, 1961.*

Not from Julius

Contrary to legend, Julius Caesar was not born by cesarean section. At that time this operation was only performed on dead women. We know from his writing that his mother was still alive when he was 48 years old.

Numa Pompilius—the second lengendary king of Rome (715 to 673 B.C.)—decreed that, if a woman died while she was pregnant, the infant was to be immediately cut out of her abdomen. This decree became part of the Lex Regia (King's law), which—under the emperors —became part of the Lex Caesare (Emperor's law), so that eventually the operation became known as the Cesarean or Emperor's operation. *John W. Ritter, M.D. Postmortem Cesarean Section. JAMA. Feb. 25, 1961.*



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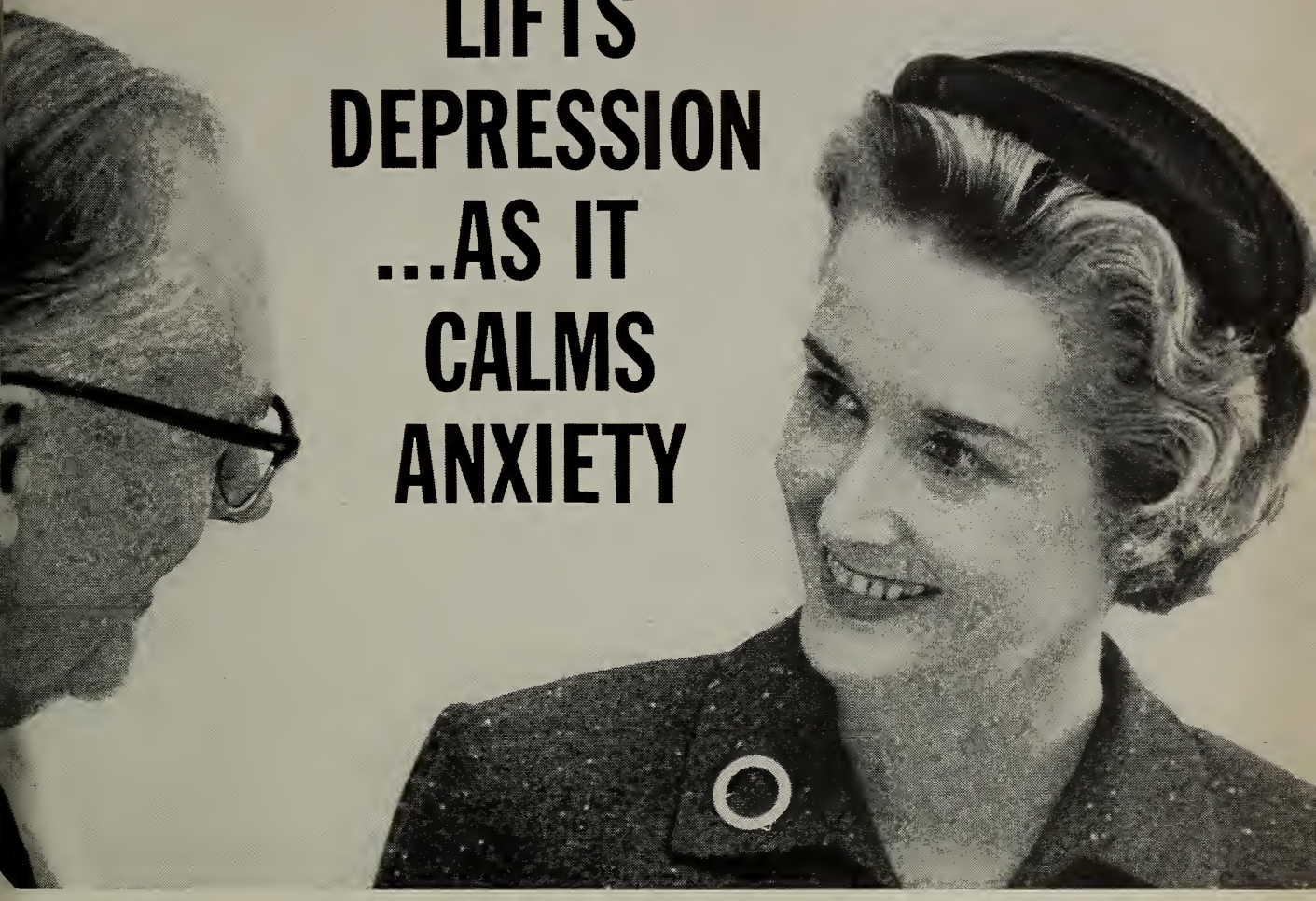
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Deprol's balanced action avoids "seesaw" effects of energizers and amphetamines. While energizers and amphetamines may stimulate the patient – *they often aggravate anxiety and tension.*

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These "seesaw" effects are avoided with Deprol. It lifts depression as it calms anxiety – a balanced action that brightens up the mood, brings down tension, and relieves insomnia, anorexia and emotional fatigue.

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During my visit to the National Cancer Institute the most astounding research I saw was in the treatment of chorionic cancer and allied conditions, including hydatidiform mole, with the folic-acid antagonist methotrexate, by Dr. R. Hertz and his co-workers. Their treatment consists in the administration of methotrexate, usually intramuscularly, but sometimes by a continuous intravenous drip, in daily doses of 10-30 mg for five days. The average period of time occupied by a given five-day course was twelve days (some patients become toxic, and the drug had to be omitted sometimes on alternate days); the average number of five-day courses per patient was 6; and the average total dose of methotrexate per patient was 620 mg. *Frank Musgrove, M.D. Gynaecological and Obstetrical Impressions of a Visit to the United States. Proc. Roy. Soc. Med. December 1960.*



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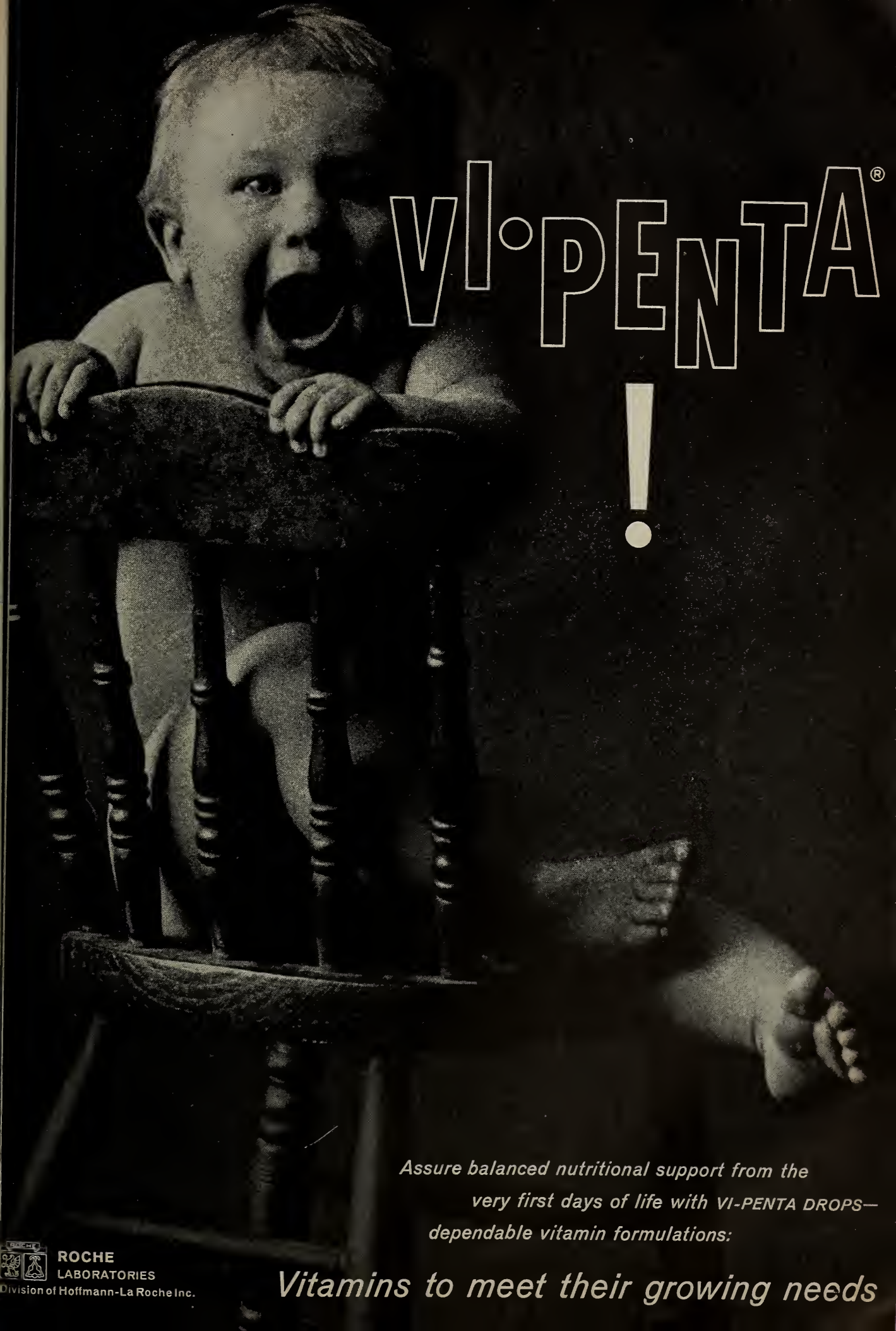
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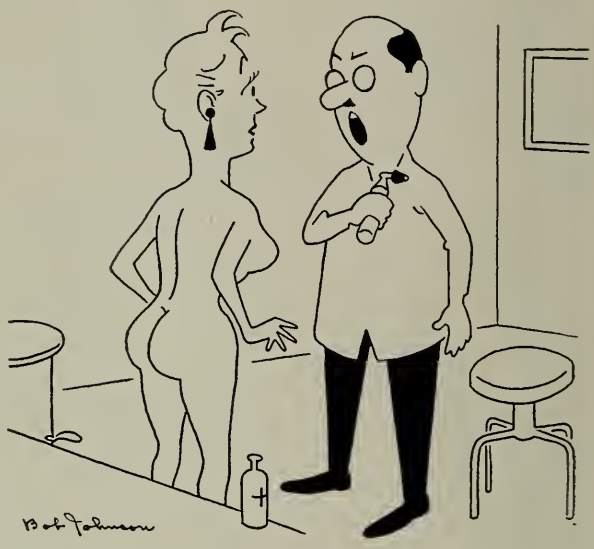
Institutionalism

In various educational systems self-determination has actually become a sin. What we may call institutionalism catches people before they are aware that they are caught. It constitutes an intricate network of social rules and directions with an inadvertent emphasis on conformity, submission, lack of initiative, and adjustment without knowing why and for what.

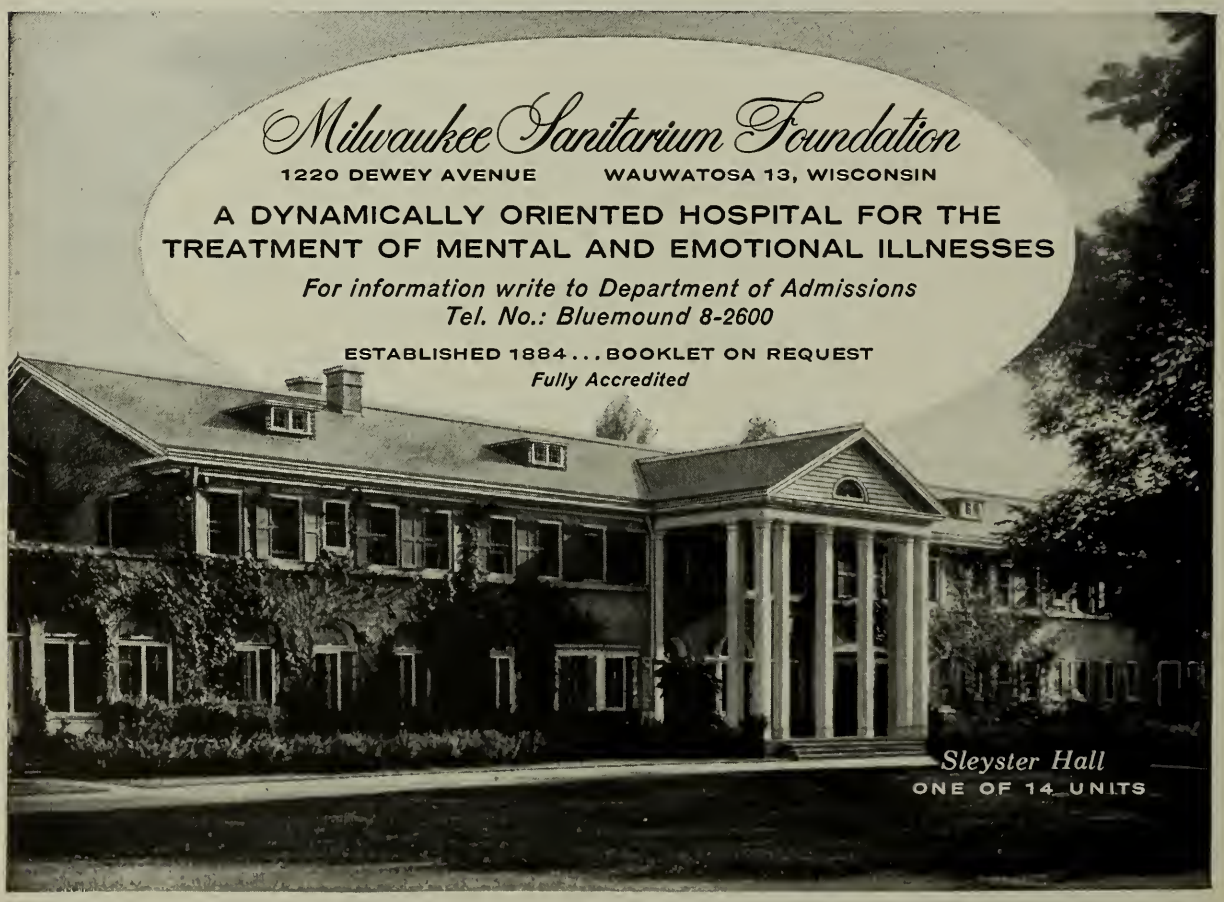
I once treated a very intelligent, active girl of kindergarten age who was rejected by her peers and her rather authoritarian teacher because of her abundance of playful initiative. Happily enough the parents could send her to another school before she was heartbroken for good.

We can recognize this type of "well-adjusted" institutionalized personality very well, for we see him among prison inmates and mental patients. The institution has become a new easy commodity for these shadows in which they can live an automatic womb-like existence without questioning the "why or wherefor." In these institutions privacy and personality hardly exist any more. Usually the bigger the institution is, the less room for any individual traits.

Townsend calls these institutionalized people the faceless ones. *Joost A. M. Meerloo, M.D. The Man Without a Face. Am. Pract. & Digest Treat. January 1961.*

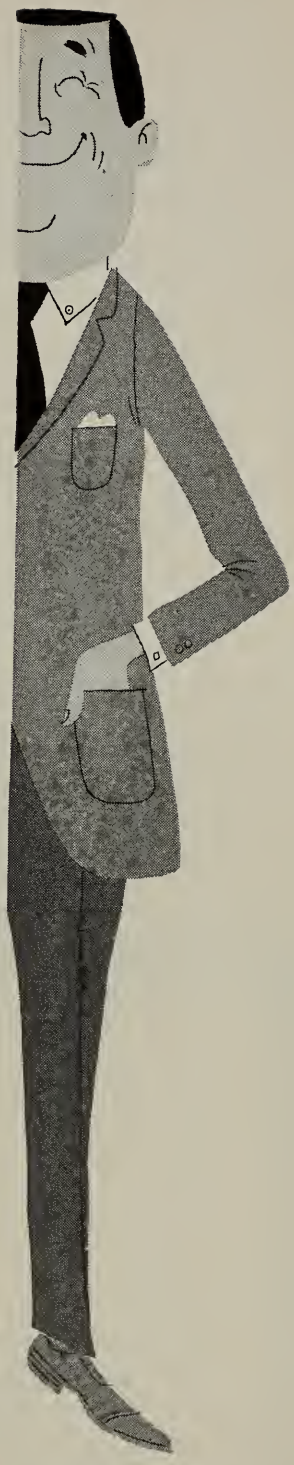


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REFERENCES: 1. Kimmig, J.: Hautarzt 3:414 (Sept.) 1952. 2. Butler, P.G.: Western Med. 1:16 (Nov.) 1960. Bibliography on request.

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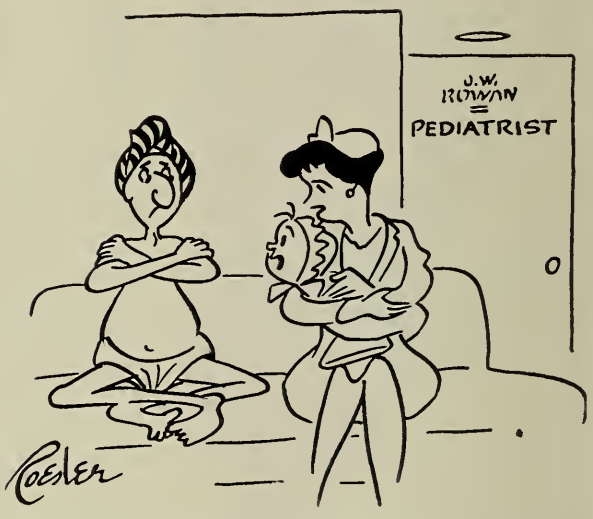
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Nucleoproteins and gout

The clinical, biochemical, and pathological findings in familial and secondary gout may be indistinguishable. The difference lies in the mechanism. Fimilial gout is considered to be the result of an increased formation of uric acid due to an inborn error of metabolism, while secondary gout represents a disturbance in uric acid metabolism due to an increased formation or destruction of blood cells.

Talbott suggests that the increase in formation of cells with the concurrent increase in the metabolism of nucleoproteins is the precipitating factor resulting in acute gouty attacks. He bases this partially on the observation that venesections may precipitate gouty attacks in polycythemia vera. It is postulated that the stress placed on the hemopoietic system by venesection and the resulting increase in nucleoprotein metabolism is responsible for the hyperuricemia. Also supporting this theory is the fact that secondary gout tends to be associated with hyperplasia of the marrow.

The association of sickle cell anemia and gout is probably rare. To our knowledge there have been only three previous cases reported. This association may be difficult to recognize since articular symptoms play a prominent role in the clinical picture of sickle cell anemia. In sickle cell anemia the increase in nucleoprotein metabolism occurring with the hyperplasia of the bone marrow may explain the acute gouty attacks. *Charles C. Smith, M.D. and Warren Kemper, M.D. A Case of Secondary Gout. J. Kentucky M. A. January 1961.*



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THE

ILLINOIS MEDICAL JOURNAL

JULY 1961
Vol. 120 No. 1

OFFICIAL JOURNAL of the ILLINOIS STATE MEDICAL SOCIETY

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Abstract of Council Actions

Meeting of June 11, 1961

IMPARTIAL MEDICAL TESTIMONY IN STATE COURTS APPROVED

It was announced that the Illinois Supreme Court unanimously approved Rule 17-2, providing for impartial medical testimony in the state courts. This was recommended by the Illinois State Medical Society as a move to speed damage suit trials.

As in the case of the federal courts, a panel of highly qualified specialists will be maintained by ISMS. From this panel, the state courts and the litigants' lawyers may draw physicians to testify in damage suits. The plan in the federal courts has proved highly satisfactory.

COMMITTEES FOR COMING YEAR APPOINTED

Committee appointments for the coming year were made by the Council. In some instances, the work of committees was combined. A few committees also were dropped because their work had been completed. In general, appointments were made to assure active participation when any committee met to deal with problems of the Society.

SPOKESMEN FOR ANDERSON-KING HEARING NAMED

Dr. Edward W. Cannady, East St. Louis, chairman of the Committee on Aging, was named to represent the Society at hearings in Washington on the Anderson-King Bill, which ties medical care of the aged to the social security system. Dr. H. Close Hesseltine, Chicago, immediate past president, was named as alternate.

SPRINGFIELD OFFICE COMMITTEE REACTIVATED

The activities in the Springfield office have increased beyond expectations. As a result, the Society may be faced with the need for increased space. A committee, consisting of Dr. Harlan English, Danville, chairman; Dr. Harry Mantz, Alton, and Dr. Jacob E. Reisch, Springfield, was reactivated with instructions to consider possible needs as they arise.

COUNTY SOCIETIES ADVERTISE KERR-MILLS PROGRAM

Reports were made that the Sangamon County Medical Society, the Saline-Pope-Hardin Counties Medical Society, and 12 other counties have used newspapers, radio, and television advertising from the ISMS kit to arouse public interest in support of SB 197 (Kerr-Mills implementation), pending in the Legislature.

PROBATIONARY MEMBERSHIP RECOMMENDATION REFERRED

Council referred to the Committee on Constitution and Bylaws for study a recommendation from the DuPage County Medical Society that a special probationary membership be established for physicians who have passed state examinations but who are not citizens. This would permit such physicians to be part of organized medicine until they are eligible to qualify for citizenship.

REPORT ON HOME CARE FACILITIES

Dr. H. Close Hesseltine, Chicago, reported that he, Dr. Henry Wilson, Peoria, and Mr. Roger White, staff director, had attended a regional workshop on home care in Chicago, May 24-26, sponsored by the AMA. "Home Care" was defined as a coordination of medicine and medical services to provide these services in the home as a supplement to hospital and nursing home care in order to promote convalescence, recovery, and rehabilitation.

Dr. Hesseltine said there are four home care programs available in metropolitan Chicago and one in Peoria, and that Visiting Nurses Association movements existed in several parts of the state. It was suggested that the Illinois State Medical Society, Illinois Hospital Association, Illinois Public Health Association, and possibly the Illinois Nurses Association should be concerned in this movement.

POLL ON SOCIAL SECURITY FOR PHYSICIANS REFERRED

The survey of the members concerning their views on social security for physicians was referred to a new committee on medical economics for implementation. The results are to be reported to the ISMS and AMA House of Delegates.

COMMITTEE TO STUDY TAX DEFERRED RETIREMENT PROGRAM

The new Committee on Medical Economics was directed to make a study of tax deferred retirement programs and to come up with recommendations. These recommendations will be submitted to the House of Delegates for approval at its next meeting or by vote through the mail if earlier action is desired.

RELATIVE VALUE INDEX DEVELOPMENT UNDER WAY

In accordance with the House of Delegates instructions, the Council directed the Committee on Relative Value (formerly Committee on Medical Economics) to proceed with the development of a "relative value index" for Illinois. The committee's recommendations will be submitted to the House of Delegates for approval before general distribution to members.

TWO RECOMMENDED FOR IPAC VACANCIES

Council voted to recommend to Governor Kerner that he fill two vacancies on the Illinois Public Aid Commission by the appointment of Mrs. Bernice T. Van der Vries, former legislator, and Dr. Edward A. Piszczek, Chicago, chairman of the Council, who is not in private practice.

ESTABLISH SECTION ON NEUROLOGY AND PSYCHIATRC

A Section on Neurology and Psychiatry was established by the Council. A special program on that subject at the last annual meeting was well received, it was reported.

EMERITUS AND RETIRED MEMBERS ELECTED

Council approved emeritus status for Dr. John W. Long, Robinson (Crawford County). The following were elected retired members: Drs. Frank L. Chenoweth, Mason City (Mason County); Philip B. Marquart, Chattanooga (DuPage County), and Gustave F. Schmidt Sr., Robinson (Crawford County).

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Second class postage paid at Mendota, Illinois. POSTMASTER: Send notices on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago 1, Ill.

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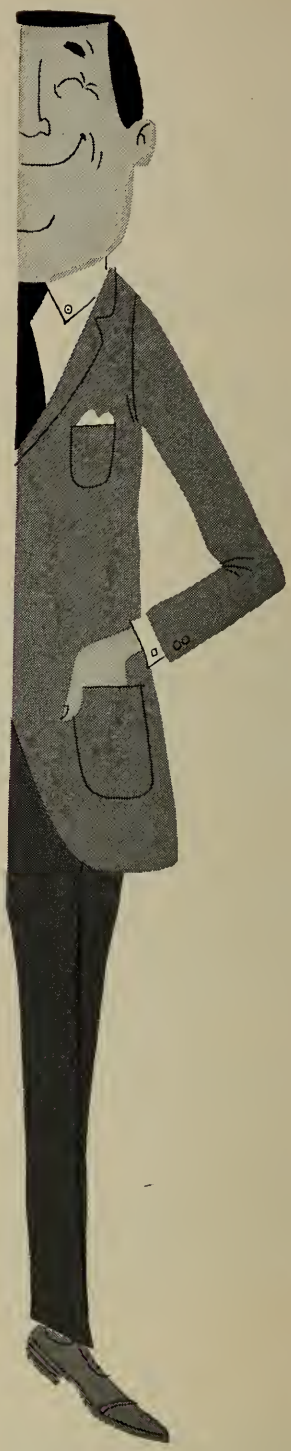
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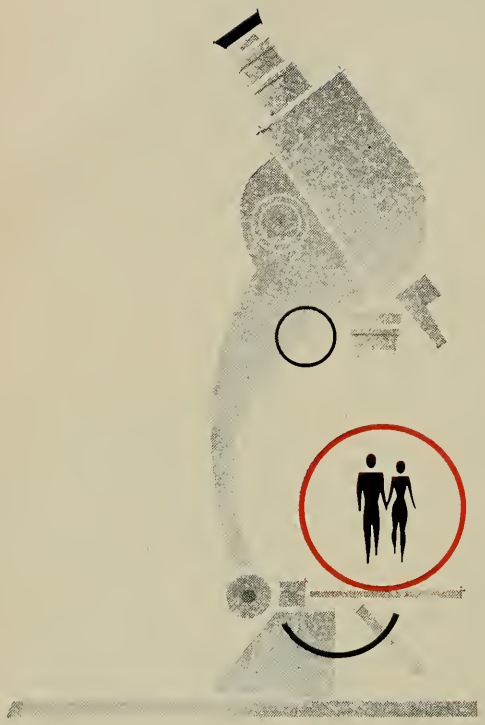
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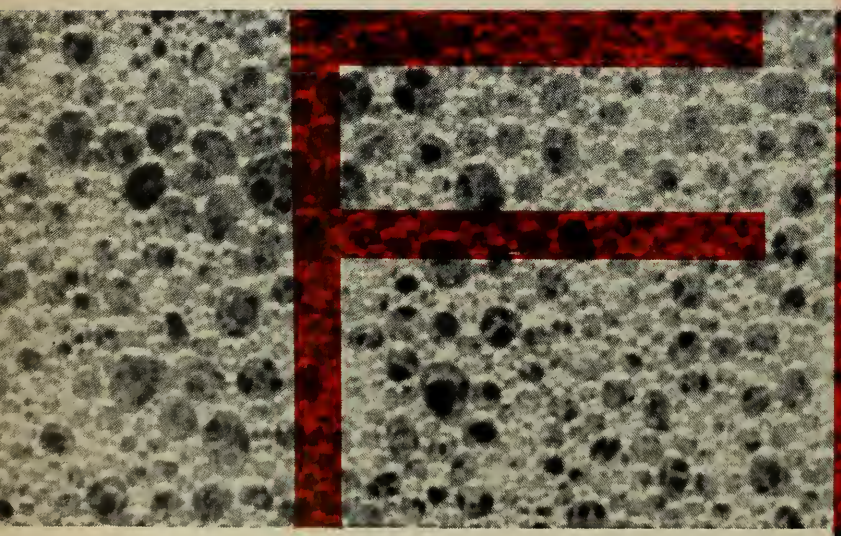
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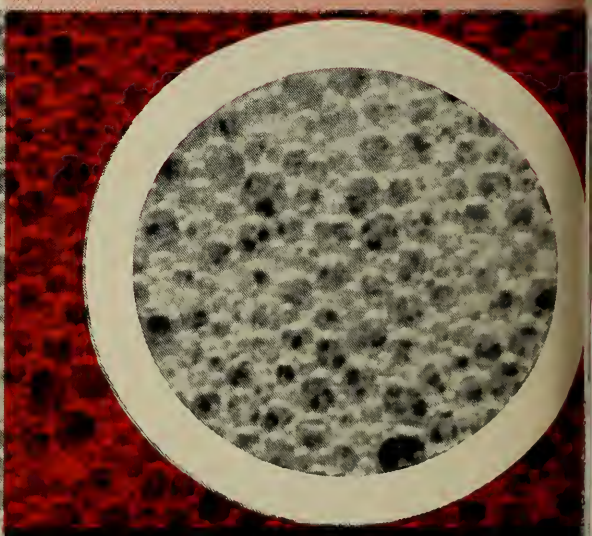
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The photo below shows Emko Vaginal Foam enlarged about 40 times. This is the network of spermicidal bubbles that provides effective coverage and blocking action.

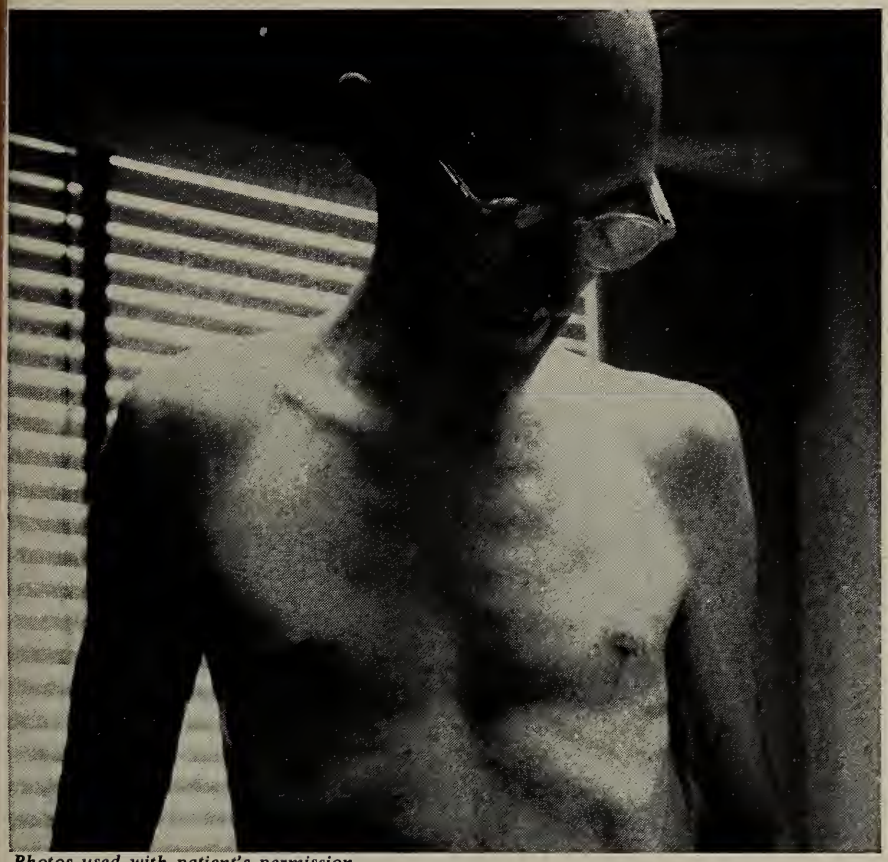




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(1) A. J. SOBRERO, M. D.: EVALUATION OF A NEW CONTRACEPTIVE (EMKO), FERTILITY AND STERILITY, 11:5:518-524 (SEPT.-OCT.) 1960

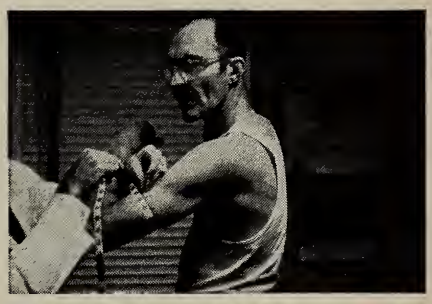


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Supplied: *Tablets*, 5 mg. (pink, scored); bottles of 100.

Dianabol®

(methandrostenolone CIBA)

converts protein to working weight in wasting or debilitated patients

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The Month in Washington



The American Medical Association supported the Kennedy Administration's proposal to provide $750 million in matching funds for construction of medical, dental, public health, and osteopathic schools.

In a letter to Sen. Lister Hill (D., Ala.), Chairman of the Senate Labor and Public Welfare Committee, Dr. F. J. L. Blasingame, executive vice president of the AMA, said; "As an Association of 179,000 practicing physicians, we are vitally interested in maintaining the high quality of medical education in the United States because of its direct relationship to medical care. For over a century, the American Medical Association has been actively and effectively engaged in the improvement of medical education in the United States. It can now be said that medical education in this country is superior to that found anywhere else in the world. It is not a coincidence that the improved standards of medical care in the last half century saw the elimination of sub-standard medical schools and diploma mills which had been turning out graduates in large numbers. This improvement in medical education is the result of the vigorous efforts of this Association and other interested organizations.

"We strongly believe that increased attention must be given to the adequacy of physical facilities, the availability of qualified instructors, and the availability of teaching material and patients for the clinical phases of medical education if high standards of medical education are to be maintained. Any attempt to increase the number of medical students without regard to these conditions will result in a lowering of the standard of medical education. We are of the firm conviction that increase in the physical facilities available for medical education should be given priority at this time over any other federal legislation in the field of medical education.

"We believe that there is need for assistance in the expansion, construction, and remodeling of the physical facilities of medical schools and, therefore, a onetime expenditure of federal funds on a matching basis, where maximum freedom of the school from federal control is assured, is justified."

The AMA opposed a provision that might encourage medical schools to expand too rapidly. Dr. Blasingame said, "It is quite possible that a forced increase in freshman enrollment would be detrimental to the quality of medical education."

The Association did not take a position on the provision of the Administration legislation that would provide federal scholarships to medical students. However, Dr. Blasingame described to the senate committee AMA's new medical scholarship and student loan programs.

The General Accounting Office found the Defense Department's Medicare program being conducted generally "in a satisfactory manner" but recommended some changes to correct what it considered "important deficiencies."

The Army, which administers the program of medical care for dependents of members of the armed services, took steps to put into effect most of the recommendations of the GAO, which audits federal spending for Congress.

However Medicare officials rejected a GAO proposal for a change in physician fees. "Our review disclosed that physicians' claims for

(*Continued on page 22*)

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medical care are, in general, significantly higher in states where maximum fees are made known to physicians than in those states where maximum fees are not made known," the GAO reported. "We estimate that there is an additional cost of as much as $3 million to $4 million annually as a result of maximum fees, rather than normal fees, being charged in the states where fee schedules are distributed to the physicians."

The GAO recommended that lower fixed fee schedules be negotiated for states where a high percentage of physicians claims are for maximum allowable fees "subject to being raised only on the basis of clearly supported evidence of higher normal fees." If lower fees cannot be negotiated, the GAO said, efforts should be made "to have the state medical society or other appropriate parties accept the responsibility for determining that physician claims are generally not in excess of their normal charges."

The GAO further recommended that "physicians be required to certify on each claim that the amount billed does not exceed the physician's normal fee for the medical care furnished."

The Army disagreed, saying that it believed "the present contracting concept is the most suitable to meet the requirements and is in the best interests of the government."

The AMA noted that it had held from the outset that "fixed fee schedules would result in a more expensive program than if physicians were permitted to charge their normal fees." Fixed fee schedules call for some fees above some so-called normal fees and others below average fees, and the AMA feels physicians tend to "balance out" by using fees listed in the fixed fee schedule.

Medicare was started December 7, 1960. During the first four years of the program, $130 million was paid to civilian doctors and $133 million to civilian hospitals for care of 1.1 million military dependents. Maternity cases accounted for about half the total.

Medicare has asked Congress for $73.2 million for the fiscal year 1962 beginning this July 1. This is a $6.9 million increase over Medicare's current budget. The increase is needed, Medicare said, because of more military dependents eligible for the program's benefits and increases in the costs of service.

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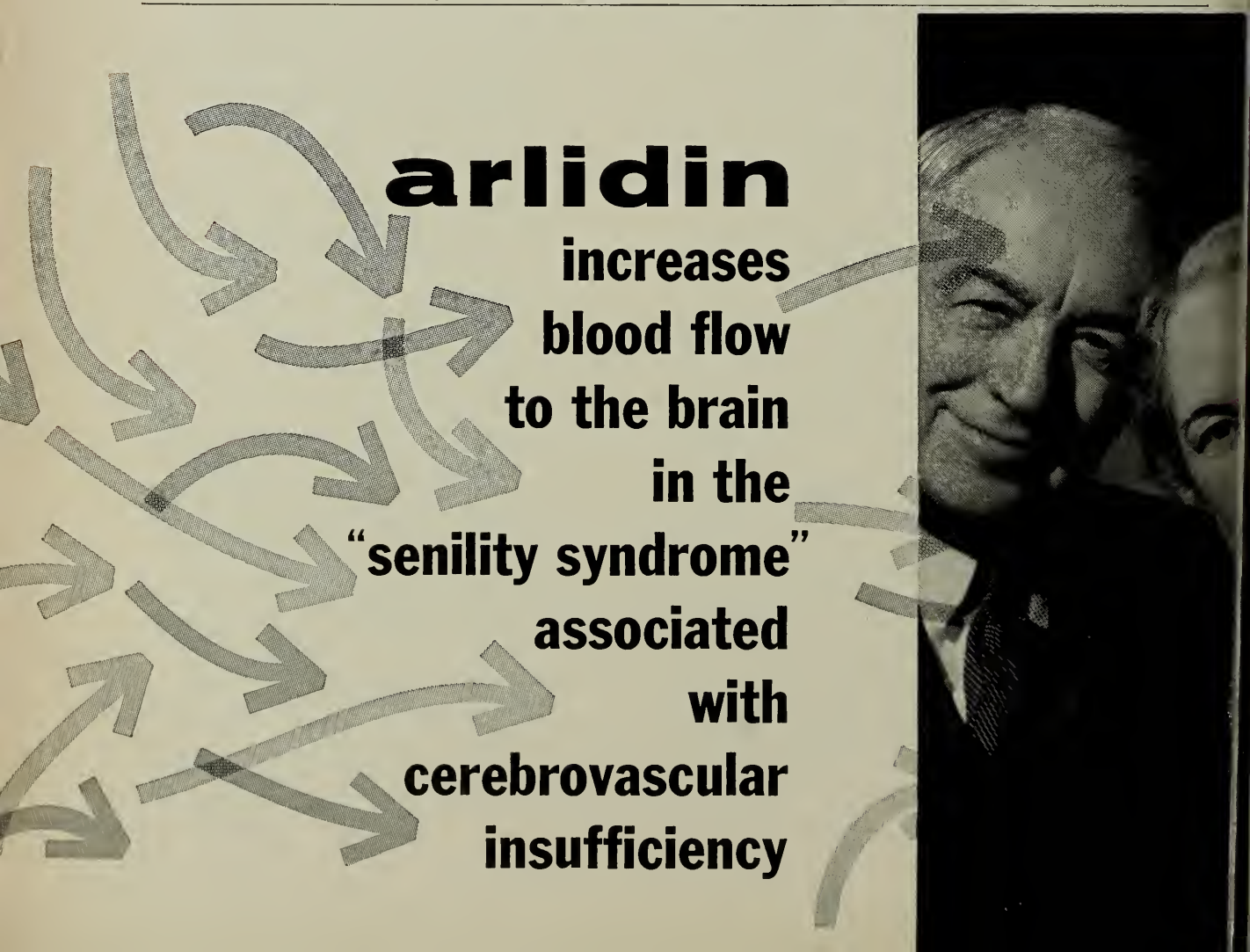
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The
ILLINOIS
Medical Journal
Official Journal of The Illinois State Medical Society

JULY, 1961
VOL. 120, No. 1

Current Problems Facing Medicine

Edwin S. Hamilton, M.D., *Kankakee*

It would be misleading not to admit at this time that I am moved as well as pleased. Any man who has spent almost 50 years in the practice of medicine and has been a member of this House for 30 years could not help being elated and grateful for elevation to the presidency of the Illinois State Medical Society. And I hope that my wife feels the same way and will continue to do so the coming year.

The past year has been spent principally in reorganizing the Illinois State Medical Society. Your officers, and especially your president, H. Close Hesseltine, and the chairman of the Council, Edward Piszczek, have given liberally their time and ability to perfect the new organization, which we see in action for the first time at this annual meeting.

Our organization is now complete, or nearly so, and only minor alterations and additions should be needed in the coming year, after we have had the "shakedown cruise." One or both of our chief officers have attended all the district meetings to explain the new organization set-up, under the executive administrator, Mr. Robert L. Richards. Collectively they have done an excellent job, and I wish to publicly voice my appreciation of their work the past year.

Now it becomes our responsibility to take a look at some of the current and future problems facing medicine today.

The first of these is to make good medical care available to all citizens of Illinois, regardless of race, color, creed, or financial responsibility. This can be accomplished only when all our members rededicate themselves to give such care to every citizen of Illinois. Service must be prompt, adequate, and kind. It must have T.L.C. quality —that is, tender, loving care—wherever and whenever needed. This is a responsibility of all medical practitioners, specialists as well generalists. Every practitioner, regardless of his special interest in medicine, should be available for the acutely ill, especially in emergencies.

This is particularly true for many of the elderly who in our present impersonal society

Presidential Address delivered before the House of Delegates at the Annual Meeting of the Illinois State Medical Society, May 18, 1961.

have been denied this tender, loving care. The medical profession should return to the image of the horse-and-buggy doctor who, while administering to his patients' physical ills, was also their father confessor. This latter service is frequently the most important factor in their medical care.

We must make adequate care available to our senior citizens. We feel that this can best be done by Health Insurance and implementation of the Kerr-Mills Bill by our state legislature. We must help to accomplish this by contacting directly the senators and representatives from our respective districts, explaining to them the urgency for appropriate action and our desires in the matter.

We must perfect our liaison with members of other professions, especially the dentists, pharmacists, lawyers, and veterinarians. Also we must establish and maintain good public relations with such nonmedical groups as the farmers, industry, and organized labor. We must indoctrinate them in our opinions and desires, and the sincerity of our position on making adequate care available to all.

We must help to preserve *freedom* of the individual man, the layman as well as the physician, in this disturbed and apprehensive world. Freedom is our most precious possession, and we must guard it jealously and militantly wherever and whenever it is in danger. This danger is often camouflaged by high-sounding phrases and promises. Remember freedom can be lost piecemeal as well as all in one action. Once lost it is seldom recovered. I would like to close with this creed, written by Dean Alfange:

> I do not choose to be a common man. It is my right to be an uncommon man — if I can. I seek opportunity, not security. I do not wish to be a kept citizen, humbled and dulled by having the state look after me. I want to take the calculated risk; to dream and to build; to succeed and to fail. I refuse to barter incentive for a dole. I prefer the challenges of life to the guaranteed existence; the thrill of fulfillment to the stale calm of utopia. I will not trade freedom for beneficence, nor my dignity for a handout. I will never cower before any master nor bend to any threat. It is my heritage to stand erect, proud and unafraid; to think and act for myself, enjoy the benefits of my creations and to face the world boldly and say, "This I have done." All this is what it means to be an American.

Again I thank you on behalf of my wife and myself for the honor accorded me today. I believe I know the problems of medicine, and I assure you that I will give you the best I am capable of during the coming year. I hope to transfer to my successor a year from now an organization stronger and more united than it is today.

Fastest with the mostest

It is fortunate that in this area of short term treatment the antiphlogistic action of the steroids does not bring us into the risk of undesirable hormonal effects, Cushing's syndrome or other. For pharmacologic effects in contrast to hormone or endocrine effects, we have an amazing range of dosage which we can use safely for this five to seven day period. We can increase it many fold over hormonal doses in most instances, and in getting this anti-inflammatory reaction one wants to be sure that the dose is large enough. In the presence of infection one must add antibiotic therapy for the underlying disease process, e.g., in tuberculosis, gram negative rod septicemia, and so on. For all of these acute infectious processes we do not have a specific therapy, but where one is recognized it is essential that antibacterial agents be combined with the steroids.

With massive short term steroid therapy it appears possible occasionally to save an eye, save a liver or save a life from death by anaphylaxis. We can use tremendous doses if we will combine the specific therapy with the non-specific pharmacological effects—I am not talking about hormone effects or replacement therapy in this zone. If we are able to stop steroids after a few days, we are staying out of trouble. *Leslie W. Whitney, M.D. Panel Discussion on the Use of Steroids. Delaware M. J. April 1961.*

Human Factors



In Jet and Space Flight*

Lt. Colonel Charles A. Berry, USAF, MC,† *Washington, D.C.*

We have the privilege of living in an exciting age, perhaps the most exciting and rapid-changing in world history. It seems only a short time ago that much of the public was traveling by horse and horseless carriage; now many fly in jet airliners. Recently a man was rocketed into space both here and abroad, and someday spaceliners will traverse the silent void of space. The new specialty of aerospace medicine is vitally concerned with the health and well-being, and thus the care and protection, of man in flight in air or space.

Any flight, whether a few hundred feet or a few hundred miles above the earth's surface, places man in an environment for which he was not designed. The constant enemy is not disease caused by bacteria or virus, but the environment. Our job is the preparation of man for flight in this alien environment; and much of it becomes preventive in nature, for after-the-fact treatment in many cases is too late. The results of environmental encounter must be anticipated, explored, and tested, and protection provided. This care and protection encompasses all of the pilot's activities, whether they be in the community, on the flight line, or flying in air or space

Some comment about the title is appropriate. It implies a broad area of coverage and indeed a book of this title was just published[1]. When one thinks of human factors today, all too often only human engineering or psychological pursuits are considered. Here, as in the book, the term is used to include the entire medical team approach to the man who flies; so perhaps medical problems of jet and space flight would be better terminology.

A recent International Air Transport Association (IATA) Conference was concerned with the problems of developing a supersonic air transport. This vehicle will travel at Mach 2 to 3 (2 or 3 times the speed of sound) and at altitudes of 50,000 to 75,000 feet. Such a vehicle is a tremendous undertaking and will be flying at what may be called space-equivalent altitudes. Thus we may discuss many of our jet and space problems together.

As might be suspected, the old enemy, Environment, is also responsible for most of the problems encountered or anticipated in manned space flight and supersonic jet flight. Today I would like to discuss some of the medical implications of this environment. These problems may be generally divided into those developing as a result of altitude or distance from the earth's surface, such as hypoxia and dysbarism, and those which are not directly a result of altitude, such as weightlessness and isolation. Some limit must be declared, and so the various problems will be briefly discussed with emphasis on only a few.

The air envelope and the space outside it are a continuum called the aerospace. The medical problems met in space flight are for the most part merely an extension of those known in aerial flight. This can best be illustrated by a discussion of space-equivalent altitudes. These are altitudes, many well within the flight envelopes of current aircraft, at which the effect of some environmental hazard is as severe as it would be in actual space. The area from sea level to 50,000 feet is frequently termed the zone of physi-

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**Oration in Medicine presented at the 121st Annual Meeting of the Illinois State Medical Society, May 17, 1961.*

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ological insufficiency, for even here man must have certain equipment to maintain his normal physiological functions. The area extending vertically from 50,000 feet to 120 miles is termed the partially spaee-equivalent area, for here many of the environmental factors produce physiologieal responses as severe as those eneountered in space. Above the 120 mile level all conditions may be eonsidered totally space-equivalent for man. Thus we see the geophysicists or astronomers definition of spaee as beginning at the 600 mile level has little significance for man, for he is beset by the many astronautieal problems long before that altitude is reached. Let us now take a closer look at some of these space-equivalent altitudes.

The environment at sea level is the blanket of air — the atmosphere — providing protection for man's rather delicate physiological funetions. As we aseend toward the flight level of supersonie transport, we have less and less of this proteetive blanket, and thus our environment is drastically altered in the 50,000 to 70,000 feet area[2]. The tolerance levels are somewhat forgiving at eonventional aircraft flight levels, but at the altitudes of the supersonic transport and the space vehicles there is virtually no margin for error.

Pressure

The most obvious environmental ehange noted at 50,000 feet is the tremendous reduetion in atmospherie pressure to only 87.3 mm. Hg or 1.69 psi. At 60,000 feet it is further redueed to 54.1 mm. Hg or 1.05 psi, and at 70,000 feet to 33.6 mm. Hg or 93.52 psf (lbs./ft^2). This low pressure is not suffieient for man's physiological needs, and several important problems are thus created. In order of occurrenee, they are decompression with its physieal effects and resulting hypoxia, anoxia, dysbarism, and ebullism.

Decompression

Though it is not direetly related to a space-equivalent altitude, the subjeet of decompression is pertinent to our discussion. It is common knowledge that in order to maintain a habitable cabin environment current airliners eompress the ambient air to ereate pressure differentials of rather significant values across the eabin walls. Some typical jet airliners have pressure differentials in the 8.2 to 8.7 psi range. While this pressure allows a comfortable and safe cabin altitude (approximately 6,700 feet), it also creates a hazard of loss of this pressure and sudden exposure to ambient altitude. At 60,000 feet a pressure differential of 9.06 psi would be necessary to maintain the cabin at 10,000 feet and 9.86 psi to maintain 8,000 feet, which would be more desirable. Rapid decompression would expose the occupants to physical injury, hypoxia, anoxia, dysbarism, and ebullism. Such decompressions have occurred with discouraging frequency and are due to loss of hatches, canopies, doors, astrodomes, windows, and to failure of the compressor system. Massive structural failures, as in the Comet, would be disastrous and must be prevented. This has been accomplished by using the "tear-stop" design. Attempts to preclude total pressure loss have been made by use of multiple compressors and fail-safe pressure valves. Designers have also created doors and windows which are plug-shaped to stop outward loss of these struetures. Audible signals of pressure loss and rapid descent of the aircraft are also safety measures currently in use. Oxygen masks which are presented automatically are also at long last standard equipment on the jetliners.

The magnitude and the rate of the decompression are determined prineipally by the pressure differential between cabin and outside, the size of the cabin, and the size of the opening through which the cabin is deeompressing. A 2′ × 2′ opening in a fighter aircraft would be of considerably more concern than the same opening in the fuselage of a jetliner. There have been many inflight decompressions in our fighter-type aircraft, but the low pressure differentials (2.5-5.0) have prevented physical damage. These low differentials are made possible by the use of oxygen equipment and/or pressure suits.

The large jetliners offer protection by the size of the cabin slowing the time of decompression. If the airway is open, there should be no difficulty following such a rapid deeompression. It is possible to render the situation more hazardous by speeding the decompression and having a elosed glottis that interferes with escape of the expanding gases in the lungs. One death has occurred in the altitude chamber from an individual holding his breath during a decompression from 8,000 to 22,000 feet. The expansion of saturated (with water vapor) body

gases at altitudes of 50,000 to 60,000 feet is a cause of some concern.

The relative expansion of a saturated gas at 37 C. (body temperature) is determined by using the following formula:

$$\frac{V_2}{V_1} = \frac{P_1 - 47}{P_2 - 47}$$

where:

- $\frac{V_2}{V_1}$ = ratio between the final volume of gas (V_2) and the initial volume (V_1);
- P_1 = the initial pressure;
- P_2 = the final pressure; and
- 47 = the pressure of water vapor at body temperature expressed in millimeters of mercury.

By using this formula, a decompression from 8,000 to 50,000 feet would produce a gas expansion of 12:1; and if the decompression were carried to 80,000 feet, it would be 80:1. These ratios are for unopposed expansion and would be modified by tissue resistance. The initial quantity of gas is of great importance in such situations, for the large quantity in the intestinal tract could produce great pain. Small amounts expanding in very sensitive or critical areas would also pose a problem, however.

The two important factors in estimating the hazard are the relative gas expansion (RGE) and the time of decompression. The latter is determined by the following equation:

$$t = 0.22\ (V/A)\sqrt{\frac{(P-B)}{B}}$$

where:

- V = volume of pressurized cabin in cubic feet;
- A = cross section area caused by structural failure, in square inches;
- P = cabin pressure in mm. Hg; and
- B = actual flight altitude pressure in mm. Hg.

The maximum tolerable decompression conditions for man can be plotted in terms of RGE and time of decompression. The line so determined would represent a maximal design limit for tolerable decompressions including a margin of safety. It is always important in discussing man's tolerances to emphasize that the engineer must not design to man's tolerances but to his comfort level.

Hypoxia and anoxia

Oxygen comprises 21 per cent of the available pressure at sea level and therefore has a partial pressure of approximately 159 mm. Hg. When this pressure drops below 109 mm. Hg (found at 10,000 feet), there is not enough force to drive the oxygen across the lung membrane in sufficient quantity to maintain the body's needed supply. This results in a condition termed *hypoxia*. The physiologic effects of this condition are well known to airmen and are not consistent with flying safety. Blurring of vision, diminished night vision, faulty judgment and poor coordination, headache, dizziness, and eventually unconsciousness result. The decreased night vision may be noted at altitudes as low as 5,000 feet, and other symptoms develop in the unprotected shortly after 10,000 feet is reached. Both military and civil aviation have long recognized this problem; there are firm rules concerning the use of supplementary oxygen supplied by mask and regulator and, in military aviation, by pressure suits at altitudes in the 50,000-foot range.

The current jetliners have automatically presented oxygen masks available for passengers, and the crew has masks constantly available and one crewmember on oxygen when flying at altitudes above 35,000 feet. There has been considerable controversy concerning the amount of oxygen which should be available on such flights and, also, when and by whom it should be used. The current Federal Aviation Agency regulations, based generally on the recommendations of ARP-505 of the Society of Automotive Engineers committee on oxygen, are sound and have ample experimental evidence to support them.

Barron[3] studied 154 subjects who were decompressed from 8,000 to 30,000 feet in 12 seconds. The time of useful consciousness (TUC) at 30,000 feet with subjects at rest in an ideal environment is from 40 to 74 seconds. Some 40 per cent of these subjects had used oxygen equipment previously; and still their mask-donning time increased with delay in descent from 30,000 feet until, with 60-second delay, they were unable to don their masks at all. With only 20-second delay, 88 subjects experienced hypoxia symptoms (lightheadedness, dizziness, and faintness), and 11 became confused and disoriented. All did apply their masks by the

time 15,000 feet was attained, and all recovered within 30 seconds of the mask application.

Bryan[4] studied experienced aircrews being decompressed from 8,000 feet to 40,000 feet in 15 seconds. TUC's were difficult to determine, but he too found that hypoxia ensued with even a 5-second delay. The difference in reaction at 30,000 and 40,000 feet is marked, and crews should be aware of this and not maintain a false sense of security due to their response at 30,000 feet.

Bennett[5] exposed 42 airline pilots to unwarned decompressions in aircraft between 26,000 and 38,000 feet, but the cabin altitude never went over 30,000 feet. Forty pilots recognized in less than 5 seconds that a pressure change had occurred, and all perceived the change in 10 seconds. Oxygen masks were hanging in front of the pilots on quick-donning harnesses, and 36 per cent had achieved their use within 10 seconds and 83 per cent within 15 seconds. Emergency descent was initiated in all cases within 5 seconds of mask-fitting. The maximum elapsed time for recognition of the emergency, fitting of masks, and descent from 38,000 feet to 10,000 feet was 3.5 minutes. Eight pilots were decompressed in the chamber from 8,000 to 40,000 feet, from the ready position. All were able to don the masks successfully; but 3 of the 8 showed signs of impairment of intellectual function after only 5 seconds, and 3 out of 4 showed such signs after 10 seconds. All but one recovered within 10 seconds of mask application. The one developed gross hyperventilation with paresthesia, tremors, and incipient collapse. This series also confirms the fact that the individual exposed to 40,000 feet must have his mask on if he is to avoid hypoxia. The important fact to remember is that even experienced personnel had difficulty donning an oxygen mask correctly after a decompression which further reduced the TUC. Among passengers, smoking, drinking, the use of medication, and illness may all enhance the hypoxia.

It will be noted that the studies reported are concerned only with altitudes of 40,000 feet and below. What about 50,000 to 70,000-foot domain of the supersonic airliner? At 50,000 feet the partial pressure of oxygen is only 18 mm. Hg. Of even more importance, the total barometric pressure is only 87 mm. Hg, and the lung alveoli are occupied by carbon dioxide (40 mm.) and water vapor (47 mm.) to the total exclusion of oxygen. Thus exposure to this altitude results in anoxia. The time of useful consciousness would be limited to the circulation time of lungs to brain, or 8 to 12 seconds. It is quite obvious that ordinary oxygen mask presentation will be of little value at such altitudes unless the decompression rate can be so slowed that the passengers will never be exposed to the full effects of this altitude. In space vehicles the astronaut is protected first by a sealed cabin life support system and, in the event of its failure, by a full pressure suit.

Dysbarism

Dysbarism may be defined as the symptom complex resulting from exposure to reduced or changing barometric pressure.[6] It is an entity totally apart from hypoxia and may occur at altitudes where the individual is well oxygenated by use of current protective equipment. Current evidence indicates that this condition may occur at altitudes as low as 22,000 feet; and, indeed, death from severe dysbarism has occurred at this low altitude. It is difficult to ascertain the exact incidence of this condition. Exposures in low pressure chambers are not always uniform in their rates of ascent, peak altitudes, time at altitude, etc.; and cases occurring in flight have not been uniformly reported. The incidence reported by the USAF Physiological Training Program is probably the most reliable, for the conditions of exposure and the trainees are most uniform here.

In 441,000 trainees undergoing the standard chamber flight to 43,000 feet, approximately 17 out of every 100 experienced some grade of dysbaric symptom. The majority of these were trapped gas symptoms involving the ears, sinuses, teeth, or abdomen. Less than 1 of every 100 persons experiencing dysbarism symptoms requires hospitalization; of those who do, 6 of every 10 are mild cases, 4 are severe, and 2 die. Recently there has been a marked increase in inflight cases in the USAF. The majority of these involve the T-33 aircraft, but all involve jet aircraft flown at altitudes in excess of 20,000 feet with faulty pressurization systems for one reason or another.

The time of exposure at these altitudes need not be great, for in a group of severe chamber reactors it was noted that 90 per cent had been

exposed to altitudes of 30,000 feet or over for only 20 minutes or less. The basic etiology of this condition seems to be the evolution of nitrogen bubbles with undetermined roles played by vasospasm, blood sludging, and perhaps fatty livers and fat emboli. The majority of the severe cases fall among those past 35 years old who tend to be obese. Treatment still tends to be symptomatic, though the use of compression chambers to greater-than-atmospheric pressure in several recent cases appears to be very effective if initiated early enough. Dysbarism could then become a real problem if the aircraft were to survive the initial decompression and reach altitudes where oxygen equipment would provide hypoxia protection.

Ebullism

This could be simply defined as the "boiling" of body fluids without the addition of heat. At 63,000 feet the total pressure is equal to that of water vapor, and thus the only deterrent to body fluids "boiling" is the pressure exerted by body tissues. The exact altitude may vary due to body temperature and the solutes in the fluids. Water vapor has been observed in the thorax of animals at altitudes as low as 61,000 feet; and, indeed, a beaker of actual blood may be made to "boil" in the altitude chamber at this altitude by varying the temperature. It is obvious that some device such as the pressure suit is mandatory for protection against this condition. Structural and systems reliability become even more important; however, other countermeasures must also be considered.

Suggested solution

In view of the foregoing statements, we connot afford to allow total decompression of the supersonic airliner. Unfortunately, no engineer, however well-meaning, can absolutely guarantee his aircraft against rapid decompression. There has been an unhealthy dependence on rapid descent and a constant attempt by both military and civilian aircrews and agencies to go ever higher with less and less protective equipment in use or immediately available. This trend must be reversed, for there is *no* room for error at altitudes of 50,000 to 70,000 feet.

If the engineer is successful in using compartmentation, multiple compressors, and the like, and thereby limiting the extent of decompression and affording more time for descent, pressure-demand oxygen equipment will be of some value and should certainly be available. In addition, however, full consideration should be given to the incorporation of some form of automatically-actuated, individual capsule at each passenger and crew station. This is admittedly expensive in both coin and weight; but if we are to avoid returning an aircraft with dead passengers aboard, this must be considered as a possible solution to the above problems at these critical altitudes.

An additional controversial suggestion is the deletion of windows from this type of aircraft. This would provide a further safety factor, and perhaps movies or other diversions might be used as psychologic substitutes.

It should also be obvious that crewmembers of any supersonic air transport must receive detailed physiologic indoctrination including exposure in the altitude chamber.

Ozone

One of the known atmospheric toxicants of current concern is ozone. Spectrographic measurements, both in this country and in Germany, have revealed an area of increased ozone content greatest between 70,000 and 100,000 feet, with the maximum concentration at about 85,000 feet, and little or none above 120,000 feet. This ozone is produced by the action of ultraviolet light in waves lengths less than 2,000 Angstroms on ordinary oxygen. The atmospheric concentration varies with the season and with the geographic location. The concentration is lower in the fall and higher in the spring. What significance does this hold for man?

Clamann[7] has reported studies on the physiologic effects of ozone in five human subjects at sea level. Though there were great individual differences in sensitivity, irritation of the respiratory tract was observed at concentrations as low as 0.6 parts per million (ppm.) for exposure times of 30 minutes. Gross changes in respiratory function were noted after exposures to 6 ppm. for one hour. The toxicity is graphically illustrated by comparing the maximum allowable concentration (for an eight-hour daily exposure for a year) with that of other known toxicants. Ozone is 0.1 ppm., while carbon monoxide is 100 ppm., and phosgene and chlorine are 1 ppm. respectively.

The effect of ozone on rubber is well known, and intermittent exposure of equipment such as oxygen masks to even 1 ppm. for 100 hours has resulted in severe deterioration. This points up the need to use such ozone resistant products as neoprene, the silicones, and hypalon. As exposure of ozone to heat for even one second will convert it to molecular oxygen, it had been hoped that the heat generated in the high-speed compressor necessary to maintain cabin pressure at altitudes in excess of 50,000 feet would destroy the ozone. Unfortunately, the very efficiency of these new compressors depends on their speed, thus reducing the contact time of air with heat to a level where less than 50 per cent of the ozone present is destroyed. There is then concern that this small concentration will be increased by placing it in the cabin atmosphere. Studies to date have been unable to accurately relate atmospheric concentrations to cabin concentrations, and better measuring devices are needed.

At approximately 80,000 feet we reach the limit of our compressors to use ambient air to produce a habitable cabin atmosphere. We must now make a *sealed cabin* possessing all the attributes of the earth which itself might be considered a large space ship. There are many problems created in providing adequate oxygen, proper temperature, control space, and removal of carbon dioxide, water vapor, odors and wastes. Studies on various parameters of sealed-cabin existence are continuing in many laboratories. Some of the early ones were done in a small chamber at the USAF School of Aerospace Medicine.

Radiation

Ionizing radiation is of interest to crew and passengers of future supersonic transports, for there are sources of such radiation in the prepared flight envelopes of these aircraft, and certainly of spacecraft. It has been fairly well accepted that there is an increasing intensity of cosmic radiation with altitude. Various authors have estimated the dosage levels of secondary cosmic radiation up to the 60,000-foot level, and there is considerable variation. This altitude is considered the lowest level to which heavy primary particles penetrate. Their energy is rapidly dissipated between 100,000 and 66,000 feet thus reducing the hazard. It is difficult to determine accurately the effect of various radiation levels reported due to lack of data and criteria for determining satisfactory RBE (relative biological effect) of the various primary cosmic particle components. Hanks[1] has given the following estimates for an aircrewman spending 80 hours per month all at the given altitudes:

50,000 feet 460 m rem/yr. (milli roentgen equivalent man)
60,000 feet 570 m rem/yr.
75,000 feet 600 m rep/yr. (milli roentgen equivalent physical)

If one doubles this dosage to account for the effect of primary particles on the cabin structure, and thus secondary radiation, you obtain 30 m rep/24 hrs. or 1,200 m rep/yr. Assigning an RBE of 1 to one-half this dose, and an RBE of 5 to the other half, the dosage becomes 3.6 rem/yr. This compares very favorably with the recommended maximum exposure of 5 rem/yr. Jones has attempted to relate radiation dosages to possible shortening of life span. Using Jones' figures and assuming that our pilot spent all his working hours at 75,000 feet for a 30-year career, he would accumulate 108 rem. This would or might result in a 540 days' or 1½ years' shortening of the life span. This could be compared to smoking 1 to 2 packages of cigarettes per day for the same period, and this is estimated to reduce the life span by 7 to 10 years. Concern has also been expressed over the possible genetic effects of exposure to cosmic radiation. Every radiation exposure of a population adds to its burden of mutations, and most of these are harmful. The dosage increment necessary to produce a doubling of the natural mutation rate has been variously estimated from 3.1 r to over 75 r. This would take generations to occur and should be of no immediate concern.

The 120,000-foot level is space equivalent also for *primary cosmic radiation.* There is a rather constant *secondary* cosmic-ray flux at ground level, but at altitude the high energy particles (80% protons, 19% alpha particles, and 1% heavy nuclei) produce dense ionization tracts in tissue characterized by collision and thin-down phenomena. The dose levels present should produce no deterrent, however, to low orbital flight (less than 500 miles). Recently some new radiation belts were described by Van Allen from satellite data. These belts are composed of either electrons or protons in the earth's

magnetic fields forming a band at the equator 1,400-3,400 miles from the earth's surface and another at 8,000 to 12,000 miles. The estimates of radiation level are 10-100 rad/hr. A great deal more information is needed about the radiation of space before intelligent conclusions can be drawn. In order to estimate biological doses, the nature, quality, and intensity of the radiation need further definition. At present it appears that either rapid transit of these areas, utilization of the polar escape routes, or ship-shielding will be necessary.

Also at 120,000 to 140,000 feet the *ultraviolet rays* reach their full unshielded potential, and protection of the eyes is necessary.

As we climb to 400,000 feet, we enter the domain of the nemesis of all TV space travelers, the *meteors*. There has been much speculation and now some data from the satellite. They have also been studied by rockets, radio, radar, light scattering and photography, and much remains to be learned. The chance of a meteor puncturing the sealed cabin atmosphere is unlikely, however; more imminent danger results from erosion of optical, and heat-collecting and -dissipating surfaces. There are multitudinous estimates of the probability of a meteorite hit, but the range of error is 10^6; so we won't concern ourselves with them. Meteorite bumpers may be used in the design of spacecraft to offer protection.

Let us now turn to problems not related to altitude. Space flight is achieved by using a propulsive force sufficient to overcome the force of gravity and the inertia of the vehicle. This thrust implies exposure of the space vehicle occupant to accelerative force. This too is no new problem, for it is encountered in aircraft flight. The magnitude of the accelerative loads do differ, however. Approximately 828 g. seconds of exposure are required for orbital velocity and 1152 g. seconds for escape velocity. The important variables in discussing any accelerative effects are (1) the direction of the force with respect to the long axis of the body; (2) position of the body with respect to its long axis; (3) initial rate of application of force to attain peak or constant value; (4) the g.-time curve of force times duration; and (5) the resistance of the body to hydraulic displacement by muscular constriction or applied counter-pressure. Human responses to the calculated g. loads necessary to achieve orbital and escape velocities have been studied on the centrifuge. They were best tolerated with the subject tilted forward at 65°. Three successive 12 g. peaks can thus be tolerated at transverse g. The re-entry profiles can also be tolerated in this position. Recent studies have concentrated on smaller accelerations (3 g.) for prolonged periods (2 days). Much more information is needed on mixed g. fields and spin or tumbling in a g. field.

Lack of "g." or weightlessness is an interesting phenomenon resulting from speed. It has been studied for brief periods (15 to 60 seconds) in the C-131 and F-100F aircraft in parabolic flight maneuvers. In the confined fighter type cockpit performance (hitting a target ring), eating, drinking, and urination have been studied. Difficulties experienced with liquids behaving like mercury in the weightless state have emphasized the need for squeeze bottles for drinking. It is possible to eat and to urinate while weightless. In the larger C-131 cabin, motility in the weightless state has been studied. Most subjects find themselves somewhat disoriented but enjoying it. It must be emphasized that the periods of weightlessness have been brief and preceded and followed by variations in the g. field which make it difficult to draw valid conclusions. We must await the first orbital manned flights to give us substantial information on this fascinating subject.

The mental stress of space flight may be much greater than the physical ones. Alteration of normal diurnal rhythms, reduced sensory input, channelized attention, and the acute requirement for constant vigilance create a formidable array of possible problem areas. These are being studied in the laboratory, and efforts are being made to anticipate and prevent as many of them as possible. The response of the astronaut to soundless, dark isolation is noted, but this is unrealistic for we will have no such spaceships.

The response of man to noise has been well studied, and we know that levels of 130 decibels produce aural pain. The launch will be a noisy event, but the capsule should be so designed that the astronaut will have little difficulty with noise. Oscillation and vibration of the capsule are expected on re-entry, and man's reactions have been studied on the vertical accelerator and shake tables. Injury is noted at the resonant frequency of the body — 5-6 cycles per second — with amplitudes exceeding 15 cm.

The hazards may be summarized in the various space-equivalent altitudes and problems.

1. Hypoxia ..... 5,000-10,000 ft.
2. Dysbarism ..... 5,000-25,000 ft.
3. Anoxia ..... 50,000 ft.
4. Ebullism ..... 61,500 to 67,000 ft.
5. Ozone ..... 70,000-120,000 ft.
6. Primary cosmic radiation ..... 120,000 ft.
7. Ultraviolet radiation .. 120,000-140,000 ft.
8. Meteors ..... 400,000 ft.
9. Sealed cabin necessary ..... 80,000-100,000 ft.
10. Acceleration stress
11. Weightlessness
12. Loneliness—isolation
13. Noise and vibration

Though the hazards sound formidable, I have no doubt that man will fly in supersonic transports and then in space vehicles to greater and greater distances. Our goal must be to support and protect these dedicated flyers and soon the traveling public, whatever the environment.

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Polio vaccine program

Cincinnati's oral poliomyelitis vaccine program was, we feel, remarkably successful. With 181,784 persons receiving at least type 1 vaccine, the response of the public exceeded the expectations of all concerned. The return rates for the preschool children of 91 per cent for type 3 and 83 per cent for type 2 vaccines also were deemed greater than might be expected.

Admittedly, this program was designed to reach the residents of Cincinnati with all the appropriate devices of persuasion and promotion. The "bandwagon" appeal was exploited to the full. The presence of Dr. Sabin in our community had a strong influence in appealing to local pride. The action of private physicians in opening their offices as a public service for the program had inestimable value in gaining public confidence and participation.

Time, however, was against us in this project. There was not sufficient time to administer the same type of vaccine simultaneously in both preschool and school groups or to complete the school program before the expected poliomyelitis season. Ideally, the vaccine program should be started about November and completed before the onset of hot weather the next year.

No cause-and-effect relationship between the vaccine program and incidence of poliomyelitis in Cincinnati can be assumed, of course. Nevertheless, it is gratifying to report that no clinically diagnosed cases of the disease occurred in Cincinnati or even in Hamilton County in 1960, especially when contrasted with the 24 cases of paralytic poliomyelitis reported in greater Cincinnati during 1959.

One case of poliomyelitis was reported in the city in 1960, but onset of paralysis occurred only 13 days after the patient, a 25-year-old man, returned to this area from an extended stay in another part of the United States. He had received neither Salk vaccine nor Sabin vaccine, and he was never associated with any child who had received the Sabin vaccine. One case resembling paralytic poliomyelitis was reported in Hamilton County in September 1960, but Dr. Sabin and his staff were unable to isolate any poliovirus or to demonstrate any rise in titer of poliomyelitis antibodies. They have isolated and demonstrated infection with ECHO type 6 virus. *Eugene R. Porter, M.P.H. and R. Eugene Wehr, M.D. Oral Poliomyelitis Vaccine Program in Cincinnati. Pub. Health Rep. May 1961.*

Sequellae of Renal Trauma

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We would like to emphasis that one of the most difficult decisions for the urologist is when to manage severe renal injuries conservatively and when to operate. Decision is reached on hour-to-hour observation. It is impossible to generalize in renal trauma. Each case must be treated individually and one's opinion may change rapidly. Authorities hold opinions varying from one extreme of exploring all patients when any great degree of parenchymal damage is suspected to the other of treating conservatively practically all patients. Proponents of early exploration cite the possibility of late sequellae such as infection and hydronephrosis. Those advocating conservative management believe that most explorations end with a nephrectomy, and they hope that by being conservative they will save some functioning renal tissue. All certainly agree that when there is deterioration of the patient's general condition, even with active supportive therapy, surgical intervention is indicated. An enlarging mass in the region of the kidney, a drop in blood pressure, an increase in pulse rate — all indicating rapid blood loss — are absolute indications for surgery.

Constant observation in the first few days following the injury is essential, and on follow-up possible late complications should be kept in mind. Some of the late unexpected developments are illustrated in the following cases.

Case 1

A young man who was in an automobile accident received a severe blow over the right kidney with fracture of the 9th, 10th and 11th ribs; hemorrhage into the muscles and a gross hematuria developed. Intravenous pyelograms were normal, and the hematuria subsided. The patient was discharged from the hospital on the tenth day. Twenty-one days after the accident, he was readmitted with a temperature of 103 F. and a palpable mass in the right hypochondrium. Urinalysis and an intravenous pyelogram were normal, and there was no tenderness in the right costovertebral angle. Since the mass presented anteriorly, a hematoma of the liver or abscess was considered most likely. The patient was explored through an anterior approach. There was no abnormality in the liver, but a retroperitioneal hematoma was observed. The incision was closed, the patient placed on his side, and a flank incision made. Gerota's fascia was incised, and 1000 cc. of clot were evacuated followed by rather rapid bleeding. Hot laps were packed into the wound and when removed ten minutes later, the bleeding had stopped. The kidney appeared normal and was not mobilized to avoid further hemorrhage. Subsequently, pyelograms and the urine sediment have been normal.

Case 2

The reverse in treatment is illustrated in this patient, a 10 year old girl who struck her right flank against a tree while sledding down a hill. On admission, one-half hour following the accident, her pulse was rather rapid (90 per minute); there was some tenderness along the right lower rib cage, and considerable tenderness in the right upper quadrant. Spasm of the abdominal musculature was present but no rigidity. There were no other apparent injuries, no drop in blood pressure, no palpable mass, and no tenderness in the right costovertebral angle. The patient vomited once an hour after the injury, and bowel sounds were absent. X-rays taken for fractured ribs and air under the diaphragm were negative. Hematocrit and hemoglobin indicated no blood loss of any consequence. A catheterized urine sample taken on hospital admission had an occasional red cell but no white blood cells.

Intravenous fluids were started, and a Levine

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Figure 1. Intravenous pyelogram shows nonfunction of the right kidney, but the left kidney and ureter are normal.



Figure 2. Retrograde pyelogram, after two weeks of chemotherapy, shows some apparently normal upper calyces on the right side. Temperature remained elevated.

tube was inserted. The child's course through the next six days remained about the same; tenderness in the right upper quadrant continued, the bowel sounds returned, her urine was normal and her temperature only slightly elevated. On the seventh day her temperature was 104 F. and her urine contained many leukocytes. The intravenous pyelogram (Fig. 1) showed nonfunction of the right kidney with a completely normal left kidney and ureter.

The patient was given Furadantin®, 100 mg., four times daily, for one week, but a culture of the urine gave a pure Proteus. For the next two weeks, she was given a course of Gantrisin®, Chloromycetin®, and Mandelamine®, but the temperature and blood count remained elevated.

On cystoscopy a few drops of purulent urine were obtained from the right ureter. No excretion of phenolsulfonphthalein dye appeared, and retrograde pyelogram (Fig. 2) showed what appeared to be some normal upper calyces. The catheter was left in the ureter for drainage, but since the temperature continued elevated for the next three days it was removed.

She then received injections of gammaglobulin, 10 cc. for the first two days and then 2 cc. daily for four days along with 250 mg. of Chloromycetin. Her temperature subsided gradually, and her urine became free of white blood cells.

The patient was discharged after seven weeks. Her urine has remained free of white blood cells for three years. Since she developed a sensitivity to the dye, no subsequent intravenous pyelograms have been made and, in a girl this age, a retrograde pyelogram would require a general anesthesia.

Case 3

Another illustrative case is that of a 7 year old girl. While wearing a snowsuit plus a coat and riding in the front seat of an automobile, the child was pushed to the floor in anticipation of a collision at a city intersection. She apparently was not seriously injured in the collision, and she remained symptom free for thirty-six hours. Then she vomited and complained of pain in her left flank. She exhibited gross hematuria and ran a temperature of 101.6 F. The child was hospitalized. A scout film of the abdomen revealed distended loops of small bowel. The chest film was clear and the blood count 3.6 million RBC, 14,000 WBC, hemaglobin, 8.9 Gm., and

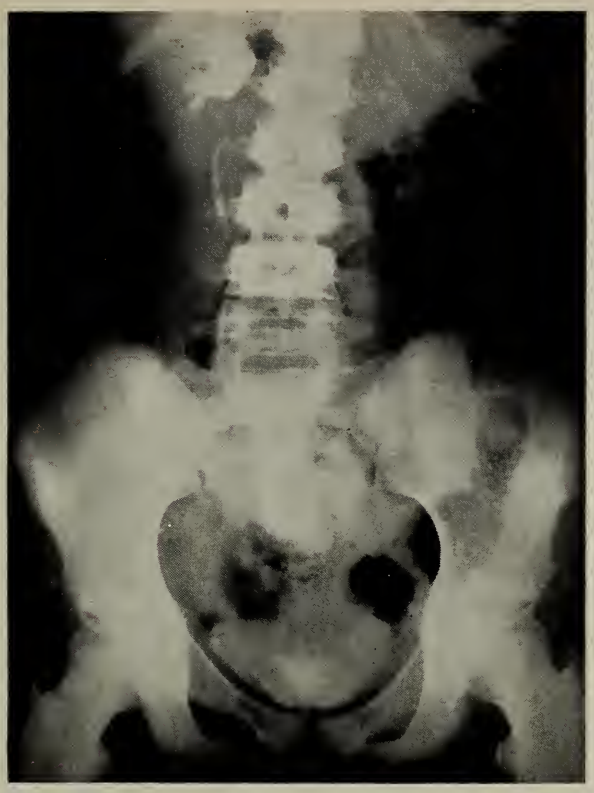


Figure 3. Intravenous pyelogram five years after injury reveals destruction of the left kidney.

hematocrit, 32 per cent. The urine contained innumerable white blood cells and 100 RBC per high power field. Intravenous pyelogram was requested, but the patient's father refused. Urinalysis showed 3 to 18 white blood cells per high power field and many red blood cells. The patient was treated supportively with intravenous fluids, antibiotics, and whole blood transfusions. After a six day hospital stay, she was released at her parents' request. The patient remained symptom-free for the next several years. An occasional urine sample revealed some white blood cells. After five years an intravenous pyelogram (Fig. 3) was performed at the insistence of the insurance company before settlement of damages; it revealed considerable destruction of the left kidney with only the lower one third functioning.

In cases of renal trauma the possibility of hypertension in unilateral renal disease is always present. Occasionally hypertension is due to unilateral chronic pyelonephritis, but in the presence of normal urine sediment the possibility of blood pressure elevation is highly unlikely. There was no instance of hypertension in the follow-up studies in the reported cases.

Summary

The problem of conservative versus surgical management of renal trauma is discussed, and three cases of renal injuries are reported. In two of the cases subsequent renal damage was out of proportion to the apparent initial trauma. In the third, late hemorrhage was severe. In the case of late bleeding, the perirenal hematoma was evacuated; otherwise the cases were treated conservatively. There were no fatalities, none of the patients developed hypertension, and some renal function was preserved with conservative management.

Caloric restrictions

As part of the National Dairy Council program on nutrition research and health education, new materials are constantly being prepared with current information of interest to professional and consumer groups. Recently prepared are the "Calorie Restricted Diets for Weight Reduction" for physicians and dietitians to assist in counseling with patients having weight problems. Previously similar weight control sheets were at the 1,400 and 1,800 calorie level. The new series has been expanded to include 1,000 and 1,200 calorie levels. An explanatory sheet for the physician is also available giving him guidance in use of this material; however each diet has been outlined so clearly that a patient could understand them if an explanation was not possible. *National Dairy Council. March 31, 1961.*

Clinical-Surgical Conferences



Cook County Hospital

Perforated Peptic Ulcer

Moderator:
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Discussants:
FREDERIC W. PRESTON, M.D.
Professor of Surgery, Northwestern University Medical School; Chief Surgeon, Veterans Administration Research Hospital
E. LEE STROHL, M.D.
Clinical Associate Professor of Surgery, University of Illinois College of Medicine, Attending Surgeon, Cook County Hospital

Dr. Robert J. Baker: The conference this morning deals with a serious complication of a disease very frequently encountered in this hospital. Perforation of a peptic ulcer represents one of two immediately life-endangering events which may occur in a patient with this disease, the other, of course, being hemorrhage. Neither of these complications is a rare occurrence, and a recent review of our material here revealed that about 1,900 perforations were treated during a 20 year span, almost 100 cases per year.

This same study[1] more significantly indicated that of 8,451 patients admitted with confirmed peptic ulcer disease, 1,904 had perforated, or approximately 22 per cent of *hospital* patients were treated for perforation. Proper emphasis has been placed on the necessity for early treatment and the consequences of delay; some other aspects of management will also be brought into focus today.

Our speakers bring with them a wide experience in this field. Dr. Frederic W. Preston is professor of surgery at Northwestern University Medical School and chief of Surgical Service at Veterans Administration Research Hospital. Dr. Preston received his early experience at the Mayo Clinic and has also been on our associate attending staff. Dr. E. Lee Strohl is a most highly regarded attending surgeon here at Cook County; he is clinical associate professor of surgery at the University of Illinois College of Medicine and attending surgeon at Presbyterian-St. Lukes Hospital.

I am certain that both speakers can shed considerable light on the more difficult aspects of the problems to be presented.

Case 1

Dr. D. Snyder, surgical resident: The patient was a 58 year old white male painter. He was admitted to the surgical service of the Cook County Hospital seven hours after onset of sudden severe pain in the epigastrium which had spread to the rest of the abdomen in 20 to 30 minutes. He took baking soda for relief but without benefit; the pain became more severe, and the patient also complained of shortness of breath.

The patient had been hospitalized on two previous occasions with severe abdominal pain and was treated with antacids, anticholinergic drugs, diet, and sedation; but he failed to follow any of the management outlined when he was discharged from the hospital.

Physical examination revealed an acutely ill patient, pallid and sweating, with a blood pressure of 100/50 mm. Hg, pulse 120 per minute, respirations 30 per minute and regular. The chest was clear except for decreased diphragmatic excursions. The abdomen was rounded, extremely tender throughout, rigid, and with diffuse rebound tenderness. A few markedly hypoactive bowel sounds were heard.

Laboratory work-up demonstrated an hematocrit of 49%, white blood count 16,800 with 78% neutrophils. There was 1+ albuminuria. Serum amylase was 16 units/100 ml., urine amylase 128 Wohlgemuth units. Blood urea nitrogen was 14 mg./100 ml. Roentgenograms of the chest and abdomen were taken.

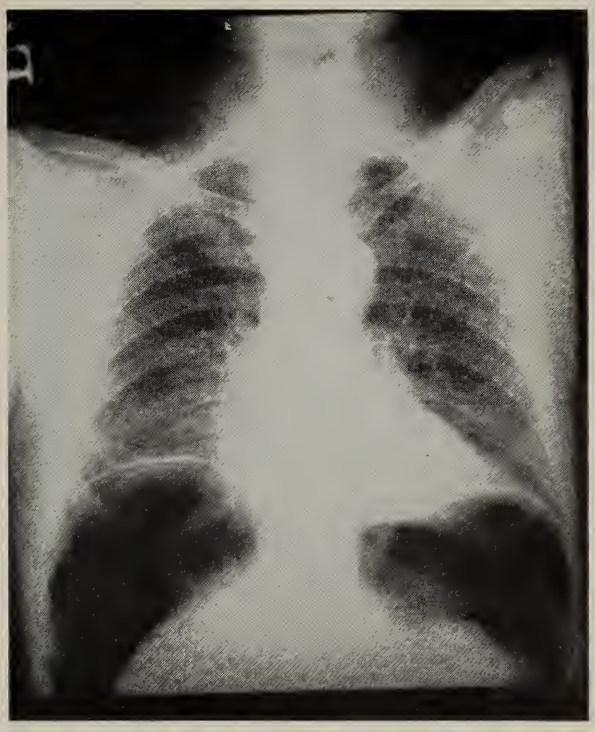


Figure 1. Upright posteroanterior view of the chest showing marked amount of free air under the hemidiaphragms indicating perforation.

Dr. Baker: Before discussing this problem, we will show the chest film (Fig. 1) obtained on admission. It shows a tremendous amount of free air beneath both hemidiaphragms. There was some question as to whether this patient had been perforated only seven hours. There were also several other interesting aspects about the case which we will ask Dr. Preston to discuss. If there were no free air, would you be deterred by the urine amylase? What would be your operative approach, and how would you prepare the patient?

Dr. Frederic Preston: Earlier Dr. Baker told me that they see 80 to 90 cases of perforated peptic ulcers a year. We do not see that many at the Veterans Research Hospital. Perforation of a peptic ulcer is a serious complication of peptic ulcer. It carries with it a high mortality, and I would like to say something about that in a minute.

With regard to the amylase, I do not know what normal is for your institution.

Dr. Baker: Between 8 and 32 units in the serum, 8 and 64 units in the urine.

Dr. Preston: I would pay attention to the serum amylase, which is within normal limits. Other things than pancreatitis cause elevation of serum amylase. Some drugs do it, morphine being one. Perforated peptic ulcer will cause an elevation because there is a high amylase content in pancreatic juice, and perforation will allow that fluid to be liberated. If the history was suggestive of peptic ulcer, I would operate regardless of the serum amylase level. If you do not have free air in the peritoneal cavity and you do have an acute abdomen which might be diagnosed as pancreatitis, the serum amylase is very important. I saw a patient just before this conference who may have a perforated peptic ulcer. We made an effort to demonstrate free air but could not. The serum amylase is normal. If the serum amylase had been significantly elevated, we might have made the diagnosis of acute pancreatitis. This illustrates how much importance is attached to this determination.

As to free air, an effort should be made to demonstrate its presence, which establishes the diagnosis of a perforated viscus. If it is not seen on the initial film, one should wait, or one can put air in the stomach via Levine tube and attempt to demonstrate it under the diaphragm in that manner. Your residents are about like I was, I imagine, when I finished my residency and was ready to go out into a community to practice. You may find that x-ray technicians

in your community don't take the films the way you want them done. It is important to have the x-ray tube at the exact level of the patient's diaphragm. If this is not done, small amounts of free air will be missed because of the angle of the x-ray.

The mortality from perforation of peptic ulcer is a bout 10 per cent in many institutions.

Dr. Baker: It is about 12 per cent here in perforated duodenal ulcer but is higher with gastric ulcer perforation.

Dr. Preston: In the past it has been about 30 per cent. There is a reason for this drop in mortality, based primarily on better anesthesia and better preoperative preparation.

In a series of cases reported on this subject the point was made that perforated peptic ulcer does not have to be operated upon immediately after the patient gets to the hospital.[2] It is mandatory to establish the urine output, reverse the patient's hemoconcentration, correct the hypovolemia with plasma, and administer solutions containing sodium and potassium to reestablish normal electrolyte balance. If these things are done, the patient is in much better operative condition than he would be otherwise. The severe peritonitis that occurs can be reversed up to a point, and it is better to spend a few hours in correcting deficits than to operate right away. Published articles give a very interesting regime for accomplishing this. Fluid shifts in perforated peptic ulcer, just as in pancreatitis, are much greater than was appreciated in former years. There is expansion of the thiocyanate, or radioactive sodium, space which represents extracellular fluid. This may amount to four liters or more and must be taken into consideration.

Before these new methods were available, it was known that these shifts existed, but their magnitude was not appreciated. Fluid is lost into the peritoneal cavity through the perforated ulcer and by vomiting, and as a result there is an electrolyte shift. Further fluid is sequestered into the peritoneal cavity. One of the most important electrolytes is potassium, and it is the one that has been understood the least. Faulty potassium therapy has contributed to the mortality in the past. One must give potassium to these patients. At the Massachusetts General Hospital, where these data were collected, patients with perforated peptic ulcers and peritonitis were given 75 mEq. of potassium a day, and that kept them in adequate potassium balance. At our hospital we give about 100 mEq. per day. Potassium administration was in ill repute for a long time because too much can produce cardiac arrest. It must be given slowly, and the patient must be closely observed. Furthermore, potassium must be given in a dilute solution. If not enough potassium is given, complications such as ileus, alkalosis, and cardiac arrest occur. The understanding of this phenomenon has reduced mortality, and this is one reason that you have a low mortality rate here.

Dr. Baker: If you had a patient with no free air but with this elevation of amylase, what would be your management? He has a history of previous pain, but the amylase elevation suggests pancreatitis. Would you introduce air into the stomach or wait?

Dr. Preston: There are three courses open for management of perforated peptic ulcer: (1) conservative treatment without operation, (2) operation with simple closure, and (3) gastric resection. One can get good results with any of these methods, and studying the conservative method is worthwhile, even though you do not believe in it. If there is no free air under the diaphragm, only a small perforation, if any, exists. If present, it probably is only pinpoint in size and not large enough to liberate much air. That patient will do well on conservative management. One can treat him like a pancreatitis patient and get good results. It is worth trying to demonstrate free air, and I would take another x-ray four hours later, being sure that the patient is in an upright position and being sure that the hemidiaphragms are centered on the film.

Dr. Baker: Do you inject air into the stomach?

Dr. Preston: I have done it, but not very often. I think it is a good idea.

Dr. Baker: We do not do it ordinarily, but I don't see anything wrong with it. With regard to potassium administration, how do you replace potassium in an acutely ill patient who has only 300 cc. urinary output with a 1.010 specific gravity? If you are not sure whether renal disease is present, would you still give potassium without a good urine output?

Dr. Preston: One of the contraindications to potassium is anuria or oliguria, and I would not give it until the patient had good urine output.

Dr. Frederic de Peyster, attending surgeon: Unfortunately, it has not been our privilege to know Dr. Roger Vaughan, who pointed out that about 85 per cent of perforated peptic ulcers in this hospital, based on a very large survey, showed free air; and the remaining 15 per cent had no air. With regard to the detection of air by roentgenologic means, our x-ray department has demonstrated that it can be done in three ways: (1) serial x-ray examination; (2) induction of air or pneumogastrium by putting air through a Levine tube, and (3) by putting the patient in a left lateral decubitus position where smaller volumes of air can be detected.

This is of historical interest only: In the years 1930 to 1936, three classical articles appeared dealing with the *forme fruste* type of perforation, edited and authored by Dr. Harry Singer and Dr. Roger Vaughan, both attending men of this institution. This type of perforation treated successfully by medical means only has been alluded to, and this is the situation where a small perforation is walled off by contiguous structures, such as the gallbladder, omentum, or liver. These patients will not ordinarily require surgery. This method was quite successful, but it does not supersede good surgical judgment, namely, acquiring the knowledge as to when to operate and repair these ulcers by direct surgical suture or some other means.

Dr. Baker: The original article is in *Surgery, Gynecology & Obstetrics,* about January of 1930, and it is an extremely interesting one.[3] Nothing has been changed in the description of the syndrome since that article was published.

Dr. Strohl, will you elaborate on some of the important points in this problem?

Dr. Strohl: I would like, first, to commend Dr. Preston for his pertinent remarks. I couldn't disagree with anything he has said. His surgical principles are sound, and, if I had a perforated peptic ulcer, I would like to have someone like Dr. Preston care for me.

I would like to say a word of caution about x-rays. If you take an upright view of a patient in whom you suspect a perforated peptic ulcer, be sure that the patient is in the upright position for at least 15 minutes. We have learned the hard way, that it requires a few minutes for the air to rise within the abdomen, when the patient has been lying supine for some time.

I would also like to make a comment about the use of potassium. As you know, with regard to potassium, particularly in the older patient, we do not use it postoperatively for a period of 48 hours. However, as has been pointed out, there is a loss of potassium in these patients which must be replaced, and this should be done slowly and continuously, not intermittently.

As to when to operate upon these patients and what to do, as a fundamental, I would say the less done the better. By that I mean that once the patient is brought into optimum condition and surgery has been decided upon, I think the least that is done — namely, closing the perforation — the better the end result will be. However, recently we have been following a new regime, and I would like Dr. Preston's opinion of it. When these people appear on our ward and the perforation has been closed, we prepare for a gastric resection three weeks later, when indicated. Much to our surprise, at operation the adhesions are rather filmy and thin, and the resection can be carried out rather easily. However, if we wait six to eight weeks, the scar tissue has begun to form in many of these ulcerated areas, and it is almost impossible to get a good duodenal stump closure. So we close the perforation early, then schedule selected patients for resection later.

We do this because of the type of patient we deal with here, the socioeconomic cripples. It has been a surprise to me, having been here just about two years, to compare the patient with perforation in this institution with those we encounter at Presbyterian-St. Lukes Hospital. The patients here are economic and social cripples; they cannot and will not follow a diet; they are regular patrons of taverns. If such a patient is discharged from the hospital two weeks following closure of a perforation and nothing definitive has been done, within a short period of time many will return with ulcer complications. We had a patient about three months ago who came in with his fourth perforation of a duodenal ulcer. These patients cannot hold a job, will not follow a diet, and shortly become wards of the county. It is our duty to rehabilitate such a patient as quickly as possible. We have been very gratified with such management.

I want to say a little about definitive surgery at the time of closure. I am sure most of you are familiar with published statements that early gastric resection carries the same mortality rate as closure of a perforation. In the type of ulcer that we see here, and the type of patient we see here, that is not true. Our patients cannot withstand a formidable operative proeedure in the face of peritonitis. We know the patient has a chemical peritonitis at the time he is approached, and to do a definitive resection rather than close the perforation is, to me, something to be condemned.

In terms of elevation of the amylase, I think the picture is entirely different with a perforation than it is with an acute hemorrhagic or necrotizing pancreatitis. I think the best clinical means of differentiating the two diseases can be done with the patient lying flat on his back in bed with his arms at his sides; go up to the bed and shake it. If the patient has a perforation he will invariably go into spasm with severe pain. The patient with pancreatitis does not have the same type of reaction. Frank perforation causes a chemical reaction on the peritoneum, and shaking the abdominal contents will invariably cause the patient to go into a spasm and have board-like rigidity of the abdomen. This was pointed out to me a long time ago by a superb clinician, Dr. Fred Gaarde. I have never seen it fail.

The electrolyte problem, the fluid problem, the blood substitutes, and improved anaesthesia are factors that have made the difference in the mortality rate in the disease. We are no better technically than we were 30 or 40 years ago. The armamentarium we now possess makes it possible to reduce the mortality from 25 to 10 per cent.

Dr. Baker: Suppose you operated upon this patient. What would be your procedure? Would you do anything other than close the perforation?

Dr. Strohl: I would put in two or three sutures, tie them to close the defect, and pull a tag of omentum over the closure, nothing more. I use several liters of warm saline and thoroughly irrigate the abdominal cavity. In World War II in our General Hospital overseas we had wires running across the operating room with fluid in large gallon jugs, and we would slide those back and forth and irrigate continuously. I think we do not do enough irrigation of the abdomen. All the recesses must be thoroughly washed with saline, and the spillage removed.

Dr. Baker: If this were a perforated gastric ulcer, how would you manage it?

Dr. Strohl: That is much the same problem. If it is on the lesser curvature and is large, with much induration about it, I would do definitive surgery at the time. I would not attempt to do a simple closure. If it were a small perforation on the gastric side that was punched out without much induration, I would do the same type of closure as with a duodenal ulcer. I had one a short time ago and thought I was dealing with carcinoma. It was 10 cm. across and 1 cm. in thickness, and I said to the house staff that it was extensive carcinoma. We did a resection, and the pathologist reported a benign ulcer. I have never seen anything like it. However, the small, clean, punched out gastric ulcer should be simply closed.

Dr. Baker: What if you had both a duodenal and gastric ulcer?

Dr. Strohl: I would handle the perforation and do definitive surgery at a later date.

Dr. Baker: What about perforation of a marginal ulcer?

Dr. Strohl: We had one of those this week. They are handled the same way, by a definitive operative proeedure. We did a resection of the anastomotic area and vagotomy. A feeding jejunostomy and a temporary gastrostomy were also carried out.

Dr. Baker: I would like to ask the same questions of Dr. Preston. How would you handle a perforated gastric ulcer?

Dr. Preston: I would close the perforation. About 10 per cent of gastric ulcers in most series are malignant, so I would take a biopsy, but that is all I would do.

Dr. Baker: With perforation, would you do gastric resection or vagotomy as an emergency procedure?

Dr. Preston: We should remember that peptic ulcer is a benign disease. Most of this audience are going out into practice. It is quite likely that one of the first cases you will get will be someone—possibly the president of the local bank—with a perforated ulcer. You are at the

hospital at 6 p.m. while everybody else is playing golf. If you do a gastric resection and that patient dies, you will wish for the rest of your life that you had just closed the perforation. If you do a gastric resection, you are doing an operation that has a mortality of 7 to 15 per cent, when you could have done one with less mortality.

Dr. Baker: What about the giant duodenal ulcer in which closure would compromise the duodenum?

Dr. Preston: I would close the ulcer with a piece of omentum. In that case, if the duodenum is obstructed after closure of the ulcer, the patient may go into a long period when he cannot eat. This is not as serious a condition as it used to be because salt-free albumin is now available. Sometimes the stomach does not drain because of stomal edema. It does not take much edema of the tissue in the vicinity of the ulcer to obstruct the duodenum. I have seen obstruction subside following 50 cc. of salt-free albumin intravenously. One can carry a patient for quite a few days and keep him from losing weight with fat emulsions and salt-free albumin and plasma; you do not have to operate on these patients right away. I had a patient with an obstructed gastroenterostomy who remained obstructed 42 days. Then the obstruction disappeared, and the patient has been all right since. Twenty years ago we thought such patients had to be operated upon right away, but this may be a fruitless undertaking.

Dr. Baker: How much fat emulsion do you give?

Dr. Preston: About 500 ml. a day for 14 days. Then do a prothrombin time and bleeding time; if they are normal, more fat emulsion may be given. You can give 1,000 ml. a day for 7 to 10 days. I do not give more than 14 units of 500 ml. each because of changes in coagulation which may cause hemorrhage.

Dr. Baker: What about perforated marginal ulcer?

Dr. Preston: These are rare in my experience. I suture the perforation as I would a duodenal ulcer and do a definitive procedure later.

Dr. Baker: I would like to ask some of the other surgeons here what they would do in a patient with a long ulcer history and a small anterior perforation of a duodenal ulcer without much spill?

Dr. Willis Diffenbaugh: I agree with Dr. Strohl and Dr. Preston: simple closure. The only place resection is indicated is in ulcer on the gastric side with a question of malignancy. Lymphosarcoma particularly perforates on the gastric side. I would not resect gastric ulcer unless it was malignant.

Dr. de Peyster: It is important to remember that we are performing a life-saving measure in every instance. In answer to your question and under certain circumstances, I would do a primary gastric resection. For instance, if I had a patient I knew had a previous complication of peptic ulcer, that has now perforated, and I knew he would not follow ulcer management, for economic or other reasons, I would resect. When the perforation was recent, within a matter of an hour or so, and when there was very little spillage, and finally if the operative risk was commensurate with a gastric resection, I would then proceed with that operation.

Dr. Donald Kozoll: I have had the experience of seeing an ulcer perforate concomitantly with other complications. I have a patient who perforated while bleeding, a situation which I feel justifies resection at a greatly added risk. We have had patients reperforate while in the hospital; certainly such an individual presents the added problem of whether he has recovered sufficiently from the previous trouble to tolerate resection. We have seen perforation stemming from steroid therapy that justified resection at the time of perforation. We have had to resect perforations of marginal ulcers, and patients with obstruction who perforated proximal to the site of the obstruction.

I would simply state that I believe some additional complications of ulcer should be present to force my hand to do resection, because I believe that 75 percent of these patients will recover and not require definitive surgery. Is it logical to subject all of them to resection to avoid a possible second operation in 25 per cent?

Dr. Baker: To facilitate the discussion, there is one more aspect of management. This patient did well for two days, and then his temperature

rose to 101.6 F. and he developed lower abdominal tenderness and distention, and a rectal mass was felt. A flat plate on the eighth postoperative day showed a discrete space-filling defect in the pelvis, representing classical pelvic abscess. Therefore, he had a complication of a complication. Dr. Strohl, what is your feeling about the management of a patients eight days following surgery with a temperature of 102 F., mild ileus, moderately septic, with a pelvic abscess?

Dr. Strohl: On the eigth postoperative day, he is running a septic fever and has a mass in the pelvis. I would wait for two or three days and do a rectal examination to ascertain whether I could enter the abscess rectally. If that were not possible, I would not hesitate many days longer before doing definitive drainage. Most of these can be handled by the examining finger. That would be my first step, and if it did not establish drainage, I still might give him a little anesthesia and see if I could do it with the finger, but if not, I would do a definitive drainage procedure. I would do it transabdominally.

Dr. Baker: What about you, Dr. Preston?

Dr. Preston: I agree that very often you can obtain drainage by rupturing the abscess with the finger. Occasionally, a loop of small bowel which is partially obstructed by adhesions may feel like an abscess, and it can be opened in error. If the anal sphincter is relaxed and there is not much question about there being a tense collection of pus under pressure, then I would drain it, under anesthesia, through the rectum. If I could not open into the abscess with the finger, I would use a knife. I would give penicillin, 4 million units a day, and 1 Gr. of streptomycin daily.

Dr. Baker: Do antibiotics affect the course of these abscesses?

Dr. Preston: They are useful in preventing them. If you give antibiotics from the time of the perforation, you will have fewer abscesses. Abscesses may occur in spite of antibiotics and may develop after the patient goes home.

Dr. Baker: Do you think the location of the original incision has anything to do with abscess formation? Could you outline any factor that predisposes to pelvic abscess in a case like this?

Dr. Preston: The incision in the abdomen is not a factor. Patients who are in the poorest nutritional condition are least resistant to infection. This is a more important consideration.

Dr. Strohl: I doubt that I would ever use a transverse incision for closure of a perforation. I have been embarrassed a time or two by not finding a duodenal perforation, but have found another hollow viscus that has leaked. I think a right rectus incision lends itself to the proper cleaning of the abdominal cavity. I do not want to say " always" and "never," but I am inclined to use a vertical incision for that very reason. One can irrigate all the recesses of the pelvis much better than with a small transverse incision.

Dr. Baker: We like and have used the transverse or subcostal incision, but I should point out that we have been impressed with the larger number of pelvic abscesses which occurred in that group in the last two years. Dr. William Dippel, of our resident staff, reviewed all of those cases, and the most significant early sign of intraperitoneal sepsis was a temperature elevation on the third and fourth postoperative day. Our management of the abscess is conservative until the anal sphincter is lax or the patient's condition deteriorates despite conservative measures.

Transrectal drainage of pelvic abscesses depends on the lax sphincter. If sphincter tone remains but drainage is necessary, we have always used a small McBurney incision on the side that the abscess is most prominent.

I should like to pose one more difficult question: Suppose a patient whose perforation has been closed suddenly commenced to bleed massively from the upper GI tract on the sixth postoperative day, requiring 12 pints of blood in 48 hours. What would be your management?

Dr. Strohl: First, try to save the patient. He has peritonitis and is hemorrhaging. You must treat the hemorrhage. You cannot defer surgery on the patient who is receiving six pints of blood daily and is still losing ground. I certainly would explore that patient. I would do a definitive procedure, possibly oversew the bleeding point, or transect the duodenum and insert a duodenostomy tube. I would do something definitive regardless of the previous peritoneal spill.

Dr. Baker: Dr. Preston, what would you do?

Dr. Preston: I agree. I think that this is an

indication for operation. In patients with severe hemorrhage from the upper gastrointestinal tract, treatment of the hemorrhage takes precedence over everything else. Certainly the requirement of six units of blood a day to keep the patient out of shock is an indication for surgery. The frame of mind of the surgeon is important. Make up your mind ahead of time what you are going to do. If you spend four hours operating upon a patient like this, he will probably die. On the other hand, he may stand a two hour operation very well. The length of time the patient is on the operating table is a very important prognostic factor in dealing with sick and elderly patients. I would look at the duodenum and open it through a transverse incision at the level of the pylorus. If I could not find the source of bleeding after a five minute search, I would go on to the next step, which is gastric resection. If I found the source of bleeding, I would oversew the bleeding point and then proceed to resection or perhaps use a more conservative procedure such as pyloroplasty, or gastroenterostomy with or without vagotomy.

Dr. Baker: Where is this patient bleeding from, would you think?

Dr. Preston: Not from the ulcer that was closed.

Dr. Strohl: I have not seen a patient bleed from an ulcer that was closed, but perhaps there was another ulcer that was not seen at the time of closure. Remember that many patients have more than one ulcer. Just finding one ulcer does not rule out the presence of another.

Dr. Baker: When you close the perforated ulcer, do you investigate the posterior wall of the duodenum?

Dr. Strohl: Yes, I do, but I will not do a Kocher maneuver just to look for a second ulcer. One can tell on palpating the area, usually. There is another sign, and that is the stippling that one sees with sponge massage of the duodenum. We use this often. Many times an old ulcer or an ulcer you do not know is present will appear with massage. We have taught most of our residents to use it; within 30 to 40 seconds it will outline the ulcer very easily and very clearly.

Dr. Baker: This patient had a posterior second ulcer at reoperation. His anterior duodenum and stomach were opened, and he had a huge ulcer. The duodenostomy was converted into a transverse pyloroplasty, the ulcer bed oversewn, and he was closed. Recovery was rapid. He did not have a gastrostomy. Would you routinely do gastrostomy in a patient like this?

Dr. Strohl: Yes, and I have had no complications from it.

Dr. Preston: Not routinely, because I have had trouble.

Dr. Baker: We have had considerable difficulty with gastrostomy. What is your technique, Dr. Strohl?

Dr. Strohl: I put a Foley catheter in, usually a No. 14, and pull it up against the anterior wall of the stomach and then suture it to the anterior peritoneal wall using three catgut sutures. I always put omentum at this point. I deflate the bag within 48 hours. I have a patient who has had such a tube in place six months, and with an auxiliary jejunostomy and by using the Barron pump, he has gained 40 pounds. I do not know why you should have trouble if you attach the gastrostomy tube exit to the anterior abdominal wall and put a tag of omentum around it.

Dr. Baker: We want to thank you both very much for this enlightening and pleasant hour.

Summary and conclusions

1. Acute perforation of a peptic ulcer through all coats of the stomach or duodenum allowing free escape of gastric or duodenal content into the peritoneal cavity is the most serious complication of peptic ulcer.
2. Free perforations occur primarily in males, the ratio being 25 or 30:1, males to females. It is vastly more common between the ages of 25 and 60, though it has been reported in both extremes of age, including the newborn. No age group is truly free of peptic ulcer nor of this complication.
3. Free duodenal ulcer perforations occur four or five times more frequently than free perforation of a gastric ulcer. Most of these perforations are on the anterior wall, usually at the lesser curvature of the stomach (or superior border of the duodenum), where little walling-off by adjacent viscera can occur. About 25 per cent of all acutely perforated ulcers have no history of previous symptoms.

4. "Walled-off" perforations, or penetrating ulcers, occur with considerable frequeney and probably comprise one third of so-called "intractable" ulcers, those quite resistant to medical treatment. They are usually on the posterior wall of the duodenum or along the lesser curvature on the posterior side of the stomach and are adherent to liver, pancreas, or gastrohepatic omentum.
5. The symptoms of free perforation of a peptic ulcer are usually heralded by *sudden* onset of upper abdominal pain which quickly becomes generalized. Nausea and vomiting usually follow the pain, and prostration is generally present.
6. Physieal findings are classically those of a tender, rigid, silent abdomen; the patient resists change in position, preferring to lie flat and motionless. Tachycardia and normal or slightly elevated temperature are the rule; shoek is *rarely* present until late in the course of the disease.
7. Approximately 80 to 85 per cent of perforated peptic ulcers will show varying amounts of free air on one of the usual "four views" of the abdomen. The left lateral decubitus film is invaluable in demonstrating small amounts of air and should never be omitted when pneumoperitoneum is bcing sought.
8. Surgical treatment of perforated peptic ulcer is the treatment of choice in almost all cases, especially those less than 24 hours old. The following procedures have been advocated:
   a. Simple omental graft
   b. Closure of the ulcer
   c. Excision of the ulcer and closure (with a pyloroplasty when necessary)
   d. Excision of the ulcer, pyloroplasty, and vagotomy
   e. Gastric resection

   Each has its plaee, but at this time, simple omental grafting with a free or living graft is the choice of most surgeons for closing the perforation.
9. An extremely important aspect of the treatment of the acute perforation at the operating table is a thorough cleansing of the peritoneal cavity of gastric or duodenal content, food, etc., by meticulous aspiration of the peritoneal gutters, pelvis, and subphrenic spaces. Some authors feel this is the most important phase of the surgical treatment.

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The Beef Trust

There are many other factors and problems to be considered; I have dwelt only on a few of the most obvious. However, even this incomplete story would be laeking if two other considcrations concerning the relationship of soeiety, culture, and coronary atheroselcrotic heart disease were not at least mentioncd.

Thc first is the impact of this modern epidemic, which strikes down so many males in the prime of life, on thc family structure, and on the psyche of the male as he ncars thc danger period confronted by thc daily obituary noticcs of his contcmporaries. The second consideration is based on the assumption that within the next decadc definitive proof will bc fortheoming concerning the key role of animal fats in our diet in the pathogenesis of this disease. Imagine then the socioeconomic struggle that will ensue in the effort to unseat the bull, its mate, and their by-products from the throne of the food kingdom and to replace them with fish and the stringbean. Imagine the struggle neccssary to replace advertisers with responsible and scientific hcalth advisors. Having only recently emerged searred and nonvietorious from the battlefield of cigarette smoking versus cancer of the lung, I can testify that the dairy and beef trusts, as well as thc hamburger and custard stands, will not willingly give up their vested and powerful interests. *David M. Spain, M.D. Problems in the Study of Coronary Atherosclerosis in Population Groups. Ann. New York Acad. Sc. Dec. 8, 1960.*

THE VIEW BOX

FRANZ GAMPL, M.D., *Chicago*

The patient is a Negro female, 3 years old. According to the mother, the child had not been well for the past two weeks; she had been complaining of vague pain in her stomach, diarrhea, and vomiting. At times, the child was observed to pick her hair and chew on it.

The physical examination revealed a well nourished, well developed child who was moderately dehydrated. The abdomen was tender and soft, and a mass the size of a golf ball was palpated in the epigastrium. This mass moved on respiration and palpation.

The following radiographs were obtained during a contrast examination of the upper gastrointestinal tract:

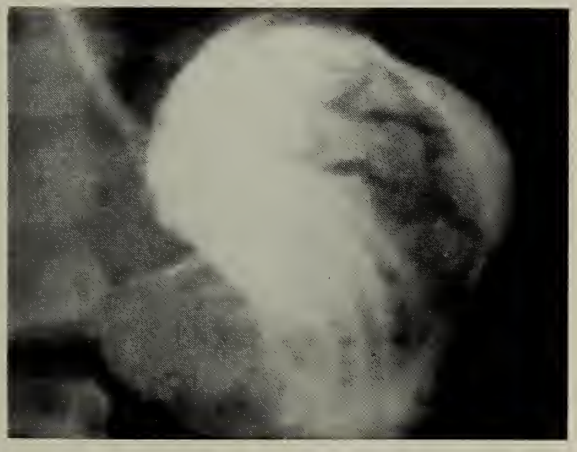


Figure 2. Spot radiograph taken at fluoroscopy

From the radiology department, Cook County Hospital

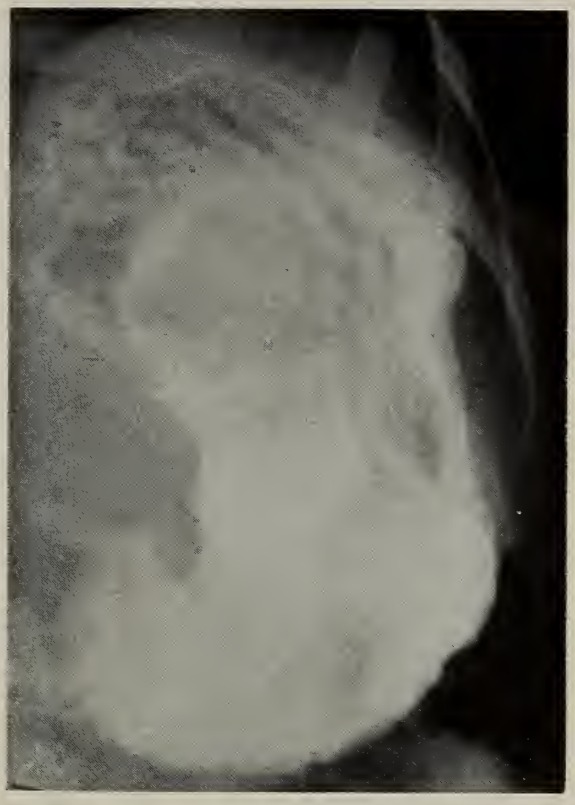


Figure 1. Posterior-anterior view

What is your diagnosis?

1) Gastric polyp
2) Leiomyoma of the stomach
3) Bezoar
4) Hypertrophic gastritis

(*Continued on page 33*)

Coffee and pregnancy

The dislike for the odor or taste of boiled or percolated coffee in one half of all pregnant patients suggests it to be a subjective symptom of an early, viable pregnancy.

Pregnant patients who develop a dislike for coffee have a very low incidence of abortions.

The "prepared coffees" were tolerated by those pregnant patients who could not tolerate boiled or percolated coffees. *Nicholas Misischia, M.D. The Dislike for Coffee as a Subjective Symptom of a Viable Pregnancy. Ohio M. J. December 1960.*

Tuberculosis in Children

A Symposium (*Concluded*)

Eugene T. McEnery, M.D. Moderator, *Consultant in Pediatrics, Municipal Tuberculosis Sanitarium*

William R. Barclay, M.D., *Associate Professor of Medicine, University of Chicago*

M. R. Lichtenstein, M.D., *Medical Director, Municipal Tuberculosis Sanitarium*

E. A. Pisczcek, M.D., *Field Director, Suburban Cook County Tuberculosis Sanitarium District*

Irving R. Abrams, M.D., *Director, Bureau of Health Services, Chicago Public Schools*

Discussion

Dr. E. A. Piszczek: There are only two things I wish to add to Dr. Barclay's fine presentation. The 1:1,000 Old Tuberculin is the standard five tuberculin units and is similar in strength to PPD.

Secondly, right now at the World Health Organization meeting in India, an attempt is being made to prepare or make available throughout the world enough standardized tuberculin material so that it will not vary from one part of the world to another. It is hoped that this will be promoted by some of the big foundations in tuberculosis research, and will be made available to all of the health agencies in the world. Basically, then, we might be talking the same language if we use the same material, and our statistics will be comparable if we all do the same good intracutaneous test. Another criticism has been that 50 per cent of physicians cannot give a good intracutaneous test. I do not think this should apply to the pediatricians.

As you came in, there were three sets of printed materials which I left for everyone to take. First, we have a pamphlet entitled, "Risk." What is risk? Dr. Lichtenstein has talked about chemoprophylaxis in contacts to known cases of tuberculosis and recent positive reactors. We agree with the findings and recommendations of the national study which the United States Public Health Service prepared about a year ago on isoniazid prophylaxis; it indicated that chemoprophylazis will eliminate 85 per cent of this risk in the reduction of complications in children exposed to active cases of tuberculosis. One thing we have learned from sad experience is that when we find a family with tuberculosis, we must take steps immediately to protect the children. If we find the mother with tuberculosis, and there are six children, there may be three positive and three negative reactors. We have had two sad experiences because of waiting for the child contact to turn from a negative to a positive reactor before putting him on isoniazid. One went into a miliary tuberculosis right under our eyes, while the test teams said to wait for the conventional reaction. Another child went into a tuberculous meningitis. So, today we have a rule that all children intimately in contact with a member of the family who has active tuberculosis, go on isoniazid chemoprophylaxis. We have had a number of children who have converted from negative to positive reactors while on isoniazid chemoprophylaxis; but in the several hundred who have a recent positive reaction, we have yet to see any cases of tuberculosis develop while the child was in isoniazid chemoprophylaxis in doses of 5 to 10 milligrams per kilogram of body weight daily.

The second sheet which was distributed is a 365-day calendar with a message for the mother

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Presented before Chicago Pediatric Society, Feb. 21, 1961.

of the tuberculin-positive child. This is an aid to help her give the medication regularly.

The third sheet contains some statistics on the problem of tuberculosis in suburban Cook County. It points up one of the problems of the statistics. You will note that in 1960 we hospitalized 16 child cases, but only six were reportable to the state as active cases under the present rules of reporting. Right now one of the great problems of the U.S. Public Health Service, as a result of the Arden House Conference, is to define what is a reportable case of active tuberculosis. One of its three tuberculosis subcommittees has been trying for about 15 months to define a reportable case of tuberculosis. I believe this committee will report within the next three months a standardized method of reporting by all agencies. We hope this will give us information on which to form a better analysis of our tuberculosis problem, state by state and city by city.

You will see in our statistics, we have always hospitalized most of the active cases in children, even though they might not have a positive gastric test. We know that even the best laboratories do not get more than 40 to 50 per cent confirmation of gastric tests on these cases. So we have considered other factors such as direct exposure, parenchymal x-ray changes, and clinical findings, as well as the positive tuberculin reaction.

Among our cases in suburban Cook County there was a total of 118 children during a five-year period. The interesting fact is that the highest incidence, of course, is in the group under five years of age — 56.8 per cent.

These figures point to another important factor here; that is need for early clinical recognition and isolation of the adult active case of tuberculosis. We can force hospitalization fairly well in the suburbs. One of the great problems in many of our American cities is that it takes too much force to apply the first law of good tuberculosis control and eradication, which is isolation of the active case of tuberculosis. In most of our large American cities, and in many of our Veterans Administration hospitals, patients leave against medical advice — the figures may be as high as 30, 40, or even 50 per cent. You cannot expect to have good tuberculosis control when these people can infect the population at will.

We have attempted to study the sources of infection among these child cases, and found that 34.7 per cent had contact to a case in their immediate families. This indicates why children and the entire family should be examined thoroughly if one family member is found with tuberculosis. Contact with other relatives accounted for 17.8 per cent; contact to neighbors, 5.9 per cent; and contact with baby sitters, 3.4 per cent. I might indicate in the last category that we have had baby sitters who came down with tuberculosis, and we were able to relieve the worries of the parents by putting the children on chemoprophylaxis. The group in which the source is not known is still the largest with 36.4 per cent.

We would like to see the tuberculin test done routinely on all children who enter a hospital (within at least the first 48 to 72 hours). It is very surprising how often you find a positive tuberculin test. There has been a massive increase in the suburban population in Cook County, 77.21 per cent in the last ten years. The study of these children reflects the changes taking place in our population. Of the 118 children, 10 were children of Mexican migrant workers; 1 Korean child adopted by an Army sergeant; 2 immigrants, one age 14, from Jugoslavia and the other age five, from Italy. There were 14 families each with two or more child cases.

We have tried to break the figures down to show how many children there were in the families. There were 25 cases that were only-children; 18 were one of two children; 25 were one of three children; 23 were one of four children; 17 were one of five children; 5 were one of six children; and 5 were one of seven or more children. A few years ago we had a case where 8 of 11 members of one family were found with active tuberculosis, six being in the sanitarium at the same time; the father and five of the children. Today with isoniazid chemoprophylaxis, I am sure this will not happen if the discovery of the tuberculosis is made early enough. Certainly we would recommend that all of the pediatricians routinely use the tuberculin test periodically on as many of their patients as possible. Certainly this is good medicine.

We do have a great deal of knowledge now about chemoprophylaxis with isoniazid, and also about the treatment of the disease. The earlier

we discover the disease, especially if it be miliary or meningitis, we will be able to treat those children successfully. It is unfortunate that children develop hydrocephalus or some other complication of tuberculous meningitis; and yet that does happen over and over again. Today with good preventive medicine, I am sure we can aid all these particular types of tuberculosis.

Dr. Irving Abrams: Since the fall of 1955, the Tuberculosis Institute of Chicago and Cook County has conducted a tuberculin testing program in selected Chicago schools. The Municipal Tuberculosis Sanitarium provided x-rays of reactors and their associates, follow-up, and treatment in many instances. The Tuberculosis Institute used 5 T.U., old tuberculin, which is 1/10 cc. of the material used, and compares with the intermediate strength PPD. The intracutaneous site is used. Since 1955 and the spring of 1960, 19 public high, 38 public elementary, 28 parochial high, and 35 parochial elementary schools were tested in all grades: 58,203 children in the public schools, and 24,305 in the parochial schools. This was a quality program but limited to only a few schools each year. Obviously it was not extensive, especially in view of the mobility of families and extension of low income areas.

An Ad Hoc Committee, with Dr. McEnery as chairman, was organized. For many reasons, the ninth grade was selected for testing and follow-up in all the high schools of the city, public, parochial, and private. Ninth grade involved children from 13 to 18 years of age, but mostly 14 and 15 year old pupils. This testing program has been under way for seven months and will be completed next month. This is the first time a wide study of the tuberculin status of a particular age group from all parts of the city has been completed in any one year. Let me bring you up-to-date on the school program from 1955 to the present time. (Slides were shown).

This slide shows cases and deaths from tuberculosis in Chicago for the past six years. Each succeeding year there has been a decline in total cases and deaths except in 1960, when there was a leveling-off with 1959. "A" cases, those which are active or probably active cases of tuberculosis, have decreased each year.

The next slide shows cases and deaths for one year, 1959. Note the preponderance of male cases, 2,597, over female cases, 1,256; and the male deaths, 253, over the femals deaths, 81. Note also 534 cases in children under five, and 113 cases from 5 through 14 years of age, also 9 deaths under five years, and 2 deaths from 5 through 14 years. After the 14 year age group, there is a sharp jump in cases and deaths. Of the 534 cases under five years, 35 were "A" cases and 499 were "B" cases; of the 113 cases from 5 through 14 years, 45 were "A" cases, and 68 were "B" cases. These figures indicate tuberculosis cases and deaths become a major problem as children get older.

The next slide shows cases and deaths with rates in Chicago, in Illinois, and the United States for the year 1940, and 1950 through 1959. Consistently through the years the rates per 100,000 population are higher in Chicago than in Illinois, and higher in Illinois than in the United States, except for 1959, when the mortality rate was seven per 100,000 in Illinois and in the United States.

The next slide shows shaded areas which represent the residential areas of low economic, nonwhite residents in Chicago. This is important when we look at the cases, deaths, and reactors by community areas.

The next slide shows seven community areas (75 in all) that have the highest percentage of reactors over a period of five years. Also shown are the number of cases by community areas, and the number of deaths. The highest percentage of reactors correlates with the highest number of cases and deaths by community areas with the exception of Area 60. Another area, 42, not shown on this chart, is the large West Side area recently populated by nonwhites, and in the last four years among the first seven highest community areas. This correlation is logical and indicates that where there is the greatest number of cases and deaths, there are the highest percentages of positive reactors in children.

The next slide shows that among the 58,203 students from kindergarten through twelfth grade tested in the five-year period, 1955-1960, in the public schools in Chicago, 15.8 per cent were reactors. The boys showed 16.2 per cent reactors, and the girls 15.3 per cent. Also note that there is a sharp rise in the percent of reactors as age advances. This correlates with the rise in reported cases and deaths as age advances.

The next slide shows a four-year analysis of reactors by sex, color, and age group in 14 high

schools and 32 elementary public schools in all grades. Significant is the nonwhite reactor incidence of over 18 per cent, and the white reactor incidence of 13.6 per cent.

The next slide shows the last year of the old program of testing all grades, the 1959-1960 school year. Please note that males and females have the same reactor incidence, and the nonwhite and white almost the same reactor incidence. This is only one year's statistics. Is it setting a trend? The answer is *No,* as will be seen later.

The next slide shows comparison of reactors in public schools with parochial schools in Chicago. The public schools showed 15.8 per cent reactors, and the parochial 11.6 per cent in all grades.

The next slide shows comparison of reactors in parochial and public schools of Chicago as compared with reactors in parochial and public schools in suburban Cook County for the year 1959. Consistently, the city schools are highest in percentage of reactors; also city parochial schools are higher than suburban parochial schools.

The 1961 program of ninth grade testing involves children from 13 to 18 years of age; most of the pupils are 14 to 15 years old. Approximately 38 public, and 43 parochial schools have been tested thus far. This program, as I have said, will be completed in March. Therefore, figures in *all* areas of interest are not available, but some important data have been gathered. In the public schools, 13,921 children, and in the parochial schools, 7,068 children have already been tested. There were 17.6 per cent total reactors in the public schools, and 12.02 per cent total reactors in the parochial schools. There were 14.6 per cent white reactors in the public schools, and 11.3 per cent white reactors in the parochial schools.

There were 23.2 per cent nonwhite reactors in the public schools, and 20.2 per cent nonwhite reactors in the parochial schools. The trend of equal reactor percentage in white and nonwhite in the 1959-1960 school year did not hold up, those for nonwhite reactors being significantly higher in ninth grade in Chicago schools than for white.

An interesting isolated finding is a private Jewish school where 55 ninth graders were tested, and 20, or 36.4 per cent, were reactors. This is a tremendously high percentage. Three of the 20 reactors are from out of the country — two from Trinidad, and one from Israel; the remaining 17 are from Chicago. This suggested that we look at two public high schools with a high Jewish attendance. One showed 23.1 per cent reactors and the other, 20.1 per cent. This indicates the Jewish ninth grade students are more widely infected than the average ninth grader (17.6 per cent).

It is apparent from these statistics that the nonwhite population in Chicago is the greatest seed-bed of tuberculosis. It is estimated there are about 75,000 positive reactors among whites and nonwhites in all grades in the public schools of the city. Add to this the number in the parochial schools, and the figure is staggering. No matter what progress has been made in the past, the danger of tuberculosis is real. The young tuberculin-positive children are the sources of new infection and new cases for many years to come if control measures are not exerted. The cases and deaths from tuberculosis at the adult level come from the group of children reactors of yester-year. A large part of the city population is seeded with tuberculosis to a greater extent than suburban Cook County.

More extensive and frequent testing on the part of private doctors and public and voluntary agencies is needed. More selected children should be treated with isoniazid, depending on the accepted indications, which need to be more widely and more frequently publicized. And tighter control over active cases is needed.

I would like to point out a second value of the tuberculin test. The first, of course, is its specificity in reactor finding. The second is its value in showing incidence of infectivity in neighborhoods and families from which the reactor children come. If a school, for example, has five per cent reactors, and another school 30 per cent reactors, the case finding should be intensified in the families and neighborhood of the 30 per cent reactors, because that is where the greatest number of open cases will be.

Moderator Eugene T. McEnery: Thank you, Dr. Abrams. We have one of our out-of-town neighbors from Milwaukee with us tonight. Dr. Kassowitz has done a tremendous amount of work on tuberculosis in Milwaukee, and I wonder if he would make some comparisons for us while we are collecting questions from the audience.

Dr. Karl E. Kassowitz: I came to listen and to learn, and I have been asked to tell you something, but fortunately not statistics. I am not authorized to give you anything about Milwaukee comparable to what we have heard from Dr. Piszczek.

However, what we have attempted to do at Milwaukee Children's Hospital Outpatient Department is to start a foolproof testing program to extend at least nearly two decades. Up to the year 1952 or 1953, we have been showing a drop in the incidence of tuberculin reactions. We used the 1:1,000 Old Tuberculin, and we still use the Old Tuberculin besides the PPD, because clinically we avail ourselves of the strongest test.

We have seen in our Outpatient Department an increasing number of Mexicans, Puerto Ricans, and late European immigrants. We have seen a drop from 7 to 8 per cent to 5 and 3.5 per cent for all ages up to 14 years in these groups. Four years ago we embarked on a program of chemoprophylaxis of positive reactors aged 1 to 3. Now the age limit has been raised to 4 years.

What we are working toward is a foolproof tuberculin test at all ages. Usually we just forget about any age limit, and take it upon ourselves to instruct the mother and try to persuade her to come back after two months for more medication. We tell her if she does, her children may stay well, or they may not; nobody knows. We, therefore, are able to report, and this will be published in the Wisconsin Medical Journal in the next few months, on our experience with three years of chemoprophylaxis in all age groups. I will say that this will not be limited to the age group of low risk, between 4 and 14 years, but we will report on the indiscriminate chemoprophylaxis of all bona fide tuberculin reactors.

Dr. McEnery: Thank you, Dr. Kassowitz.

These are some of the questions from the audience: Should INH be given to everybody who has been in contact with a case of tuberculosis? One of the recent issues of the American Academy of Pediatrics Journal has an article on the use of INH. Another question we have is why do we advise INH prophylaxis for treatment?

I would like to ask Dr. Barclay how he feels about the subcutaneous testing program in the Chicago schools. Instead of changing the needle on all children being tested, we are now just flaming the needle between tests. The question has come up whether or not this is likely to increase the incidence of infectious hepatitis. Dr. Barclay?

Dr. William R. Barclay: There is no unanimity of opinion on this. I think it can be said that in such a program the risk of hepatitis is negligible. For instance, if the test is given by experienced people, no blood is ever aspirated into the needle, and there is no blood except a drop on the skin after the test. If the needle is flamed before the next test, this should take care of it. However, theoretically, it is possible to transmit infectious hepatitis in this way. For this reason, you may wish to insist that a new needle be used for each test. Practically speaking, the risk is negligible; theoretically, it is there.

Dr. M. R. Lichtenstein: Just within the past couple of years, the Committee of the American Trudeau Society, which considered the possibility of infectious hepatitis in doing tuberculin tests, said it was all right to flame the needle between tests. Here the Committee indicated that if a platinum needle is used, it can be flamed. They quoted no cases of hepatitis in many thousands tested by this method.

Dr. Abrams: What is the relationship between attending public school and exposure to tuberculosis?

The statistics which I have presented indicate that in many instances more nonwhite children from slum areas attend public school than parochial school. The statistics also indicate that nonwhite children who attend public schools are exposed to a greater number of open cases of tuberculosis among adults and associates in their neighborhoods and homes than do children attending parochial schools.

Dr. Barclay: I might add that at the University of Northern Illinois at De Kalb the rate of positive tuberculin reactors in the entering freshmen is less than three per cent. This is an interesting comment on the social status of the negative reactors, and the possibility of getting into college if you are a positive tuberculin reactor apparently are pretty slim.

Dr. Piszczek: The question is: Do you recommend the tuberculin test be given in children

who are critically ill with pulmonary disease? I presume what the questioner meant was in case of pneumonia or something of that nature. I think there is no reason for not doing the tuberculin test. Certainly, if you need to do a tuberculin test in a child with critical pulmonary disease, you could start out with a 1:10,000 dilution; and if that is negative, you can repeat the test with 1:1,000. In the children in the Suburban Cook County District, we use 1:10,000, then 1:1,000, and even 1:100. There should be no contraindication to doing the tuberculin test.

Another question: Will INH prevent the conversion from a negative to a positive tuberculin reaction? We have had very sad experience in two cases. That was about five years ago when INH was first used in very early known contacts. Now it is known that it can be given to anybody who will take it, including all old cases. We now recommend it for all cases for chemoprophylaxis. We have found in a number of children that, if the mother has active tuberculosis, or the father, and there are several children under the ages of 1, 2, or 3, if they are put on INH right away, they will change from a negative to a positive reaction within three months. There will not be any clinical symptomatology of active disease within that period of time. In other words, INH did not prevent their getting a conversion from negative to positive reaction. They probably had some open lesions and germs in the system, but it takes roughly six weeks for the tuberculin test to convert from negative to positive. We are no longer waiting for the conversion. All positive reactors are put in isoniazid.

Dr. Lichtenstein: I have several questions. One is: What is the significance of vesicles? They merely indicate in the tuberculin test that the patient is highly allergic. It may be a recent infection, or it may be a reinfection. Frequently it just means that the patient is highly allergic. Beyond that, I think there is no significance.

Another question: How often do you repeat the test? I think in your private patients you have to use your own judgment. I think the test should be repeated in a child who has been ill with an upper respiratory infection. On the other hand, if a child goes on perfectly all right, there may be no indication for repeating the test between the ages 5 and 12. However, the Public Health Service tells us to do the test at least once a year on large groups. You can do only a few in the schools, and really this is the best way. Therefore, we are having difficulty in isolating these children and in trying to follow every child to know when he does convert.

The next question: How long do the marks from BCG vaccination last? The marks made by the multiple puncture technique may last for weeks or months, and leave no real scar.

Next: Does PAS have side reactions such as hallucinations in children? PAS does have side reactions, but not hallucinations. It may cause gastrointestinal difficulties. One should look for PAS reactions in less than one percent of persons. We have never seen it in children, only in adults, but the reactions can be quite frightening.

Dr. Piszczek: I should like to add one comment. It is known that vesicle formation is more likely in recent immigrants. We have tested close to 300 immigrants from Europe, all of whom were brought here by religious organizations for placement. We know that the percentage of these people who will break down in the next ten years is exceedingly high. It has been observed in New York that one out of five will be tuberculin positive. We test all of these with 1:10,000. I would say that about 50 per cent have vesicles, and they take a much more massive dose than any of the American population, probably from a residue of concentrated infections over a long period of time. We are placing all of these patients under at least one year of INH chemoprophylaxis, with the hope of reducing the incidence of reactivation. It is known that such people are highly susceptible to reactivation of the disease.

Dr. Barclay: I might say there is no experimental evidence for the use of isoniazid in treating patients with inactive disease. It is known there is less risk of local disease in the animal, but there is no clinical evidence to give any validity to that sort of treatment at this time.

Dr. Piszczek: Time will tell.

Dr. Abrams: The question is: Does the Board of Education conduct other programs besides tuberculosis service?

Yes, the Board of Education conducts many programs.

Another question: Does the BCG reactor enter into the statistics quoted? No, the statistics which were quoted on the ninth grade level, did not include BCG reactors.

Dr. Barclay: Does Old Tuberculin contain a protein of the tubercle bacillus? Yes, there are the large proteins, and some protein is incorporated into the media.

At what age do you recommend doing the first tuberculin test, and how often should it be done thereafter? I do the first tuberculin test at six months, and advise doing it every six to twelve months thereafter.

How do you feel about the Vollmer test, that is, the tuberculin patch test? I think it should never be used. I think you should use the best test available.

How do you feel about the policy of having the mother read the tuberculin test herself? I prefer to read the test myself.

Dr. Lichtenstein: The question is: We are putting stress in the time element in starting prophylaxis. Don't you think we are overlooking an important factor in not stressing the time element in breaking contacts with infecting cases?

Of course, I am sure all of us try to break the contact promptly when we find a man or woman with tuberculosis if there is a positive sputum. There is a court order which protects children particularly, usually by a threat, to make the man or woman enter a sanitarium.

Dr. McEnery: I wish to thank all the members of the panel for their very fine presentations, and the members of the society for their participation in the discussion.

Alcohol and cholesterol

The effect of ethyl alcohol on the serum cholesterol concentration in normal man is certainly small, and high doses of ethanol are needed to produce an elevation of serum cholesterol which reaches statistical significance. However, the fact that such an increase is produced indicates that alcohol may be of some importance in maintaining high levels of serum cholesterol in individuals drinking large amounts of alcoholic beverages and subsisting on high-fat diets.

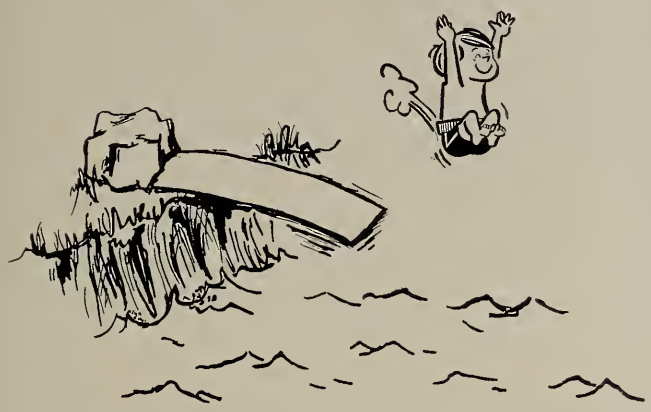
The fact that ethanol increased serum cholesterol (and other lipids) concentration in the serum of hyperlipemic individuals is important from the medical viewpoint and indicates that these patients should be advised against drinking alcoholic beverages. The same is true of essential hyperlipemic individuals and in subjects with high intrinsic cholesterol levels. The results of our experiments in men indicate that these individuals should avoid drinking of alcoholic beverages, in addition to the usual dietary measures, in order to lower their serum cholesterol levels. *Francisco Grande, M.D. and Donald S. Amatuzio, M.D. The Influence of Ethanol on Serum Cholesterol Concentration. Minnesota Med. Nov. 1960.*

Deductible health insurance

The question always arises as to whether insurance coverage with a deductible tends to hold down utilization to a significant degree. Again, I don't believe there are satisfactory statistics to prove this situation one way or another. Certainly if it has any effect, it must be in some way related to the size of the deductible and, as you know better than I do, this is a narrow line to walk since too small a deductible probably will have no effect on utilization, and too large a one will hinder patients from getting adequate care or make the insurance prepayment package unattractive and set up bad debt problems for hospitals, and political pressures for all of us to have some type of government financed care.

Since the really significant pressure for over-utilization is probably found in the cases requiring diagnostic services, a change in insurance benefits to include diagnostic services out of the hospital would go a long way towards relieving this pressure and, if it can be adequately financed, would be a significant addition to the over-all availability of health services for our people. *Russell A. Nelson, M.D. Hospital Costs and Health Insurance. Health Insurance Viewpoints. April 1961.*

MEDICINE IN THE OUT-OF-DOORS



Sink or Swim

JULIUS M. KOWALSKI, M.D., *Princeton*

For millenniums man lived on the edge of water. In that period when he was a gatherer, the beach provided him a life-sustaining existence. Plants and sea animals thrived in the shallows and were readily available. Travel, exploration, and limited commerce were possible only by water before the domestication of animals and the invention of the wheel. So man was at home in this element, respected it, and of necessity learned to maintain himself in it for limited periods. Learning to swim was as mandatory for his survival as was learning to run.

But how different and shameful is the situation today in this era of pushbuttons, rapid communications, and speed. Where is the sense of achievement in mastering basic human skills, the knowledge and respect for the environment, the assurance of resourcefulness? There are literally millions in our country today who have little or no knowledge of water, thereby expressing a morbid fear of it or outright contempt. Aboard modern water crafts replete with present day engineering ingenuity, they wrap themselves in false security. All is well until the moment they are u p e n d e d and find themselves in the water — then a hostile environment to those who did not take the time nor trouble to make their acquaintance with it under more favorable conditions. Accidents don't just happen; they are unwittingly planned mistakes resulting from ignorance or misinterpretation of facts.

To reverse the upward trend of drowning accidents, let us bear in mind that it is never too late to learn. Mature judgment is an effective counterbalance to rapid, enthusiastic learning in the young. Any adult who finds himself upon water, even as an occasional boater or fisherman, should make every effort to become a swimmer or forego these soul-satisfying recreations. It is this individual, like his Sunday-driver counterpart, lacking in proficiency, who is the greatest menace to himself and others.

But it is in childhood that the die is cast for adult life. Children can learn to swim as readily as they can learn to walk. Though a few are not much beyond infancy when they learn to dog-paddle, the majority are given group instruction after becoming of school age. Now, in the tender formative years things can augur for good or bad. Forceful ducking, splashing unexpectedly with cold water, and other pranks by older playmates can turn a youngster away from water for life. It may take many days of patient training and reassurance to undo a few moments of thoughtlessness.

Likewise, the father who has always been too busy somehow, now finding that his ego is injured since his son doesn't participate in water frolicking with others says, "I'll teach that kid to swim this summer if it's the last thing I do!" won't have a swimmer. The idea is noble, but the approach is character-shattering. Unless one has — not just thinks he has — the time and ability to teach swimming, better leave this instruction to qualified personnel. Swimming and knowledge of water is not all pleasant, exhilarating, or relaxing as so many are prone to

believe. It is at rare, critical moments, often under most adverse conditions, that earlier thorough training by competent instructors will spell the difference between life or death. No price is too high for this instruction; actually, it is most modest.

The American Red Cross has been the shining beacon for swimming and life-saving in this country almost since its inception. In close cooperation with the YMCA, schools, Boy Scouts, Camp Fire Girls, summer camps, civic recreational groups and others interested in any phase of water recreation, the American Red Cross is most willing to advise or instruct. There isn't an advanced swimmer in the country who hasn't directly or indirectly benefited from American Red Cross instruction. Preparing for disaster is its business, should it befall an individual or a whole segment of the population. In many areas, American Red Cross swimming instructions are given on a county-wide basis and an inquiry at the local office will put even the most hesitant of landlubbers on the way to becoming crusted old salts.

If you don't know how to swim, inquire today and learn this summer!

Art and science of medicine

The aim of scientific medicine should remain as it is now—a diagnosis in rigorousness and precision, a rational therapy based on this sort of diagnosis and validated under as strict conditions as possible on the model of the double-blind experiment. For some time to come this medicine will be the science of specialists, who possibly will have only a limited contact with their patients and will be able to observe only a limited field—i.e., their specialty. The other medicine, which I call medical practice, will have to forgo the ambition to become as exact as her sister. Her ambition will not be so much diagnosis in precision as diagnosis in depth; and it will be many years, possibly generations, before doctors can refine their findings and their language for describing them so that it will match the achievement of scientific medicine. As their diagnosis will not be precise, objective, or scientific, the treatment based on it will not lend itself to a validation according to the model of the double-blind experiment. They will have to develop new criteria, a different kind of scientific objectivity, which may be called *whole-person pathology or whole-person medicine,* in which the main task will be to *understand the meaning for the person of the complaints and illnesses that he offers to his doctor.* The aim of therapy will then be to *enable the patient to understand himself,* find a better solution for the problem facing him, and thus achieve the integration which has not developed or has broken down because of disturbed relationship of the individual with his environment. This is the place of psychotherapy in medicine.

Looking at the situation thus, we may say that there is no need for controversy or competition between the two medicines. What must be done, however, and must be done from both sides, is to find out what sort of conditions can be treated by what kind of methods; and it is here that great difficulties have to be expected. The tacit conclusion that hospital teachers and methods are far superior to anything else will have to be revised. In many conditions it is true, but in others the patient can get more help from general practice—i.e., from proper psychotherapy. While the methods of hospital medicine are generally more successful in dramatic or critical conditions involving life or death, general practice and psychotherapy may be more effective in securing or maintaining contentment and human happiness—which is perhaps equally important. In modest terms, we may state their aim as to free people from unnecessary miseries in everyday life. *Michael Balint, M.D. The Other Part Medicine. Lancet. Jan. 7, 1961.*

The View Box—diagnosis and discussion (*continued from page 23*)

The clinical diagnosis of a large trichobezoar was confirmed by the radiographic findings. The bezoar formed a cast of the stomach lumen and moved freely on palpation and change of position.

The rough and porous surface of the hairball remained coated with barium (Fig. 3) when all contrast material had left the stomach, thus ruling out a large, soft, and pedunculated tumor. A hairball measuring 10 × 3 × 3 centimeters was removed by gastrotomy. The recovery of the patient was uneventful.

Bezoars, concretions found in the alimentary tract of animals, were once highly prized antidotes for poisons; The name in common usage now comes from the Persian "pad-zahr" meaning antidote against poison. The first description of a bezoar in man is credited to Baudamant (1777), who found them in the stomach and duodenum on autopsy. Since that time, numerous cases have been reported in the literature. Most common are the trichobezoars and phytobezoars. The latter consist of a gluelike coagulum formed by the hydrochloric acid of the stomach with vegatable matter from the unripened fruits of the persimmon family. Shellac, varnish, nails, and other indigestible matter are less frequently found as foreign bodies in the alimentary tract.

The clinical symptoms are varied, ranging from mild gastrointestinal complaints to a severe, debilitating illness. Parts of the bezoar may appear in the vomitus or in the feces.

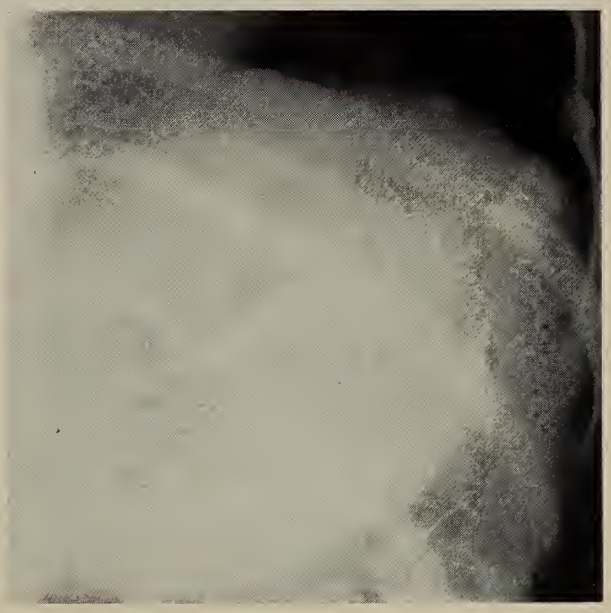


Figure 3. Follow-up study six hours after the ingestion of the contrast medium.

Complications include gastric ulcer (24-75%) and intestinal obstruction (rare).

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The dentist and oral cancer

The dental profession is aware of its important contribution to cancer control. During the last decade, the nation's dental schools have sharply increased their emphasis of teaching in the areas of oral diagnosis, oral pathology, and related fields. Most schools now present separate courses in oncology and dental student frequently attends the hospital tumor board and outpatient clinics. The recent dental graduate has had considerable instruction in the indications for the technics of biopsy and the use of exfoliative cytology studies and is aware of most aspects of the oral cancer problem. Increasing numbers of dentists are becoming qualified in the dental specialties. In most instances their training programs include considerable emphasis in the field of neoplastic disease. The increasing popularity of dental internships provides dental graduates with additional experience with the cancer patient in a hospital environment. *Minor Turrentine, D.D.S. The Dentist and Cancer. J. M. A. Georgia. April 1961.*

Motility Disturbances Caused by Prochlorperazine

Eugene F. Diamond, M.D., and Nicholas M. Limperis, M.D., *Chicago*

The phenothiazine derivatives have earned their place as most useful and effective psychopharmacologic agents during the relatively short period since their introduction. Their use in pediatrics has been related largely to their effectiveness as antiemetic agents. The side effects of the phenothiazines are well known, and bizarre extrapyramidal disturbances have been reported[1-10]. The lability of the juvenile nervous system apparently makes children more susceptible to the extrapyramidal seizures.

The purpose of this report is to describe four cases of seizures complicating short-term phenothiazine therapy and to re-emphasize the hazard of using these drugs in the symptomatic therapy of vomiting in children. Despite an extensive campaign by one manufacturer to educate the profession, the prescribing physician did not recognize the reactions herein described. Patients in each case were admitted to the hospital with a provisional diagnosis of infectious disease of the nervous system. Cases described herein were seen at four hospitals affiliated with the Stritch School of Medicine of Loyola University.

Case 1

A 13 year old white female awoke in the morning with nausea, malaise, and a fever of 38 C. She was seen by her family physician who diagnosed gastroenteritis and gave parenteral penicillin. Four hours later, vomiting supervened, and a 25 mg. prochlorperazine suppository was prescribed. The patient became extremely agitated and complained of abdominal pain. The surgical consultant ruled out surgical disease of the abdomen and recommended that the 25 mg. prochlorperazine suppository be repeated, six hours after the original dose. The patient awoke three hours later with muscle spasms involving the neck and shoulders, and she appeared terrified. She was seen at the St. Francis Hospital emergency room, where an intern diagnosed encephalitis. Pediatric consultation was obtained. Seizures due to prochlorperazine were suspected, and treatment was instituted with caffeine sodium benzoate and barbiturate sedation. The patient gradually improved over a six hour period.

Two siblings subsequently developed a similar syndrome of fever and vomiting.

Case 2

R.N., a 20 month old white male, was admitted to Mercy Hospital with a twelve hour history of fever and vomiting. Six hours before admission he had been seen in the emergency room, where a diagnosis of pharyngitis and gastritis had been made. He was given 600,000 units of Bicillin® intramuscularly and a 2.5 mg. prochlorperazine suppository as an antiemetic. Three hours later, he developed seizures consisting of sudden rigidity of all four extremities with arching of the back. They recurred every 20-30 minutes until admission. The admission diagnosis was suspect meningitis. A spinal tap disclosed clear fluid under normal pressure with two lymphocytes per cu. mm. Sugar and protein were normal. Culture subsequently showed no growth. Prochlorperazine intoxication was then suspected. Caffeine sodium benzoate was administered intravenously; seizures subsided completely after 90 minutes. The child was treated with parenteral tetracycline 20 mg./Kg./day for his pharyngitis. He was afebrile in 48 hours and was discharged after four days.

Case 3

A 12 year old white female was examined because of fever and vomiting. Her throat was

From the pediatrics department, Stritch School of Medicine, Loyola University.

inflamed and rhonchi were heard throughout the chest. Therapy was instituted with parenteral penicillin and a 25 mg. prochlorperazine suppository every six hours. Seven hours later the patient experienced severe seizures consisting of rigidity of the upper extremities and drawing of the head to the left. She was admitted to Little Company of Mary Hospital, where a spinal tap showed clear fluid under normal pressure. The spinal fluid chemistries and cell count were normal. The child was started on phenobarbital 32 mg. every four hours; seizures gradually disappeared after 12 hours. Chest x-ray disclosed a bronchopneumonia, which was treated with parenteral penicillin and streptomycin, and the patient recovered in six days.

Case 4

A 10 month old infant with vomiting and diarrhea of two days' duration was seen by the family physician who made a diagnosis of gastroenteritis. Four hundred thousand units of penicillin and 0.5 Gm. of streptomycin was given intramuscularly and 2.5 mg. prochlorperazine suppositories were prescribed. One-half hour after the first suppository was given, the child developed seizures consisting of sudden opisthotonus with rigidity and tremors of the upper extremities. He was admitted to St. Francis Hospital because meningitis was suspected. A spinal tap was done, and the spinal fluid was found to be completely normal. Calcium gluconate, 5 ml. of a 10% solution, did not relieve the condition; similar results were obtained with caffeine sodium benzoate, 0.5 Gm, intravenously. The infant was started on Artane® Elixir 0.4 mg. every six hours; the symptoms gradually disappeared over a 12 hour period. The most striking feature of this case was the persistence of a tremor of the head, much like that seen in senile paralysis agitans, for 36 hours.

Discussion

Motility disturbances with therapeutic doses of phenothiazines have been reported to result from chlorpromazine (Thorazine®)[1,2]; promazine (Sparine®)[3]; perphenazin (Trilafon®)[4,5,6]; promethazine hydrochloride (Phenergan®)[1]; prochlorperazine (Compazine®)[1,7]; trifluoroperazine (Stelazine®)[6]; and thiopropazate (Dartal®)[7]. These disturbances have been most often observed among children being treated for acute physical illnesses,[8] but are not unknown among children being treated for psychiatric disturbances.[9] All the cases in the present report had been treated with prochlorperazine. This may reflect the popularity of this product in the community or may, on the other hand, reflect that this medication is particularly poorly tolerated by children.

We used the dosage schedule recommended by Cohlan[10] for prochlorperazine. Cases 1 and 3 represent possible overdosage reactions, but cases 2 and 4 would seem to represent true drug idiosyncrasies. It has been alleged[8] that very young children are more tolerant of phenothiazine drugs; however, both the patients in cases 2 and 4 were under two years of age. Antiparkinsonian drugs such as Artane and Cogentine® are reliable, if not dramatic antidotes. Caffeine sodium benzoate is not the specific antidote it was originally claimed to be.[8] Immediate discontinuation of the offending phenothiazine is the most important phase of therapy.

Summary

Four cases of seizures following prochlorperazine therapy are presented. All cases were originally suspected to be infectious diseases of the nervous system. Drug idiosyncrasy, as well as overdosage, is implicated in the cause of the seizures. The seizures, in every case, terminated in 36 hours or less. No permanent residuals were observed. The discontinuation of phenothiazine therapy and the use of antiparkinsonian drugs constituted the most effective management.

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EDITORIALS

Phenylketonuria, "an inborn error of metabolism"

There is substantial evidence that some of the inborn errors of metabolism may cause mental retardation. Considerable attention has recently been given to this entire group of metabolic disorders since it has become known that in some of them, brain damage can be ameliorated or prevented by proper treatment.[1,2]

One of these metabolic disorders, phenylketonuria (PKU) was discovered in 1934 by Fölling[3] when he added ferric chloride to the urine of two mentally retarded siblings. The resulting color reaction was found to be due to phenylpyruvic acid.

Phenylketonuria is a recessive trait genetically transmitted. It has been estimated that the condition occurs in 1:20,000 persons and that 1:70 are carriers. About one per cent of the inmates of mental institutions have brain damage (phenylpyruvic oligophrenia) due to PKU.

The affected patients cannot metabolize phenylalanine to tyrosine due to the deficiency of a liver enzyme, phenylalanine hydroxylase. Infants born with PKU develop excessively high phenylalanine blood levels when fed either human or cows' milk. Continued ingestion of food containing large amounts of phenylalanine causes irreversible brain damage. A diet low in phenylalanine reduces the blood levels of this substance below the point of toxicity.

Phenylpyruvic acid usually appears in the urine in untreated PKU infants 4 to 6 weeks old. The lack of excretion of the substance before this time in PKU patients is believed to be due to the immaturity of the liver enzyme system which transforms phenylalanine to phenylpyruvic acid by deamination. Therefore, the diagnosis of PKU during the first month of life in suspected infants can be made only by the determination of phenylalanine blood levels.

The members of the Mental Health Committee of the Illinois Chapter of the American Academy of Pediatrics recommend that the urine of infants be tested for excessive amounts of phenylalanine at 6 weeks and again at 3 months. Children under one year of age with any of the following conditions should also be screened:[4]

1. Actual or suspected mental retardation
2. A retarded or PKU sibling
3. Nonspecific persistent diaper rash
4. Seizures
5. Peculiar odor to the urine

There are simple tests available for the detection of phenylpyruvic acid in the urine. One such test is done by applying a test paper (Phenistix®) to a recently wet diaper. When the reaction is positive, phenylalanine blood levels should be determined to establish a firm diagnosis. At the present time these determinations and being done by the laboratories of Dr. David Y. Hsia at Children's Memorial Hospital.

There are many unanswered questions concerning PKU. For example, it is not known how phenylalanine causes brain damage. Then too, there appears to be little correlation between the height of the phenylalanine blood level and the severity of brain involvement. There are a number of reports of children with proven PKU who are not mentally retarded. In some untreated children who have this metabolic disorder repeated examinations of the urine have failed to reveal phenylpyruvic acid. There is no doubt that the earlier the diagnosis is made and the low phenylalanine diet given, the better the prognosis. However, there appears to be no agreement on the length of time the special diet must be continued. Some investigators have reported that the diet may be discontinued at the age of 2 years without any deleterious effect;

others claim that it should be given for a much longer time.

The low incidence of the disease makes it unlikely that any one physician in private practice (not affiliated with a mental institution) will find more than one case of PKU in a lifetime. Yet, if every newborn infant with it were tested, 200 to 400 cases would be found each year. With proper diet, institutionalization of these children can be avoided.

The low phenylalanine diet given to PKU children should contain enough phenylalanine (15 mg./Kg.) to cover the requirements for growth. If the parents cannot afford to pay for the diet (which is expensive) they may obtain help through the Illinois Department of Public Health at Springfield.

Daniel L. Pachman, M.D.

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The phenothiazines

Elsewhere in this Journal is a report by Diamond and Limperis on motility disturbances in children caused by one of the phenothiazines. Last month we published an article by Zocchi and Dimitri on one of the new phenothiazine derivatives, "Effects of Fluphenazine Dihydrocholoride in State Hospital Patients." These drugs are becoming more popular; there are ten recommended mainly for the treatment of psychiatric conditions. Chlorpromazine (Thorazine®) is one of the original, whereas trifluoperazine (Stelazine®) is one of the latest. These two drugs serve as examples of differences in the way phenothiazine products act therapeutically. Trifluoperazine ameliorates the underlying psychotic process to eliminate aggressiveness and hyperactivity. Chlorpromazine calms by virtue of its sedative effect. The former product is better able to focus on specific symptoms, and in this respect may be preferred in treating a hyperactive individual suffering from delusions and hallucinations.

The phenothiazine group is used in the treatment of hyperactive psychotic disorders, acute alcoholism, head injury, and nausea of pregnancy and radiation sickness. Some patients respond better to one drug than another, and the general physician should familiarize himself with at least one or two of these major tranquilizers.

Side reactions also vary from drug to drug and patient to patient. These include allergic reactions, skin lesions, seizures, agranulocytosis, palpitation, engorgement of the breasts, depression, drowsiness, fever, symptoms of Parkinson's disease, and confusional states. Five of the drugs have a tendency in low dosage to produce extrapyramidal symptoms and, according to Steinhilber[1], three phenothiazines produce unusual reactions that should be recognized.

Perphenazine (Trilafon®), prochlorperazine (Compazine®), and trifluoperazine occasionally produce bizarre spasms of the perioral, facial neck, and back musculature. These symptoms develop suddenly, often within a few days and on low dosage. The second reaction is akathisia or forced restlessness. This varies from moderate inner tension with restless feelings in the legs to severe agitation with hyperactivity. A good response is obtained with antiparkinsonian drugs.

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Recruiting physicians

Approximately one fifth of all physicians have a medical family background. The majority want their offspring to follow suit, provided the youngster has the aptitude and wants to be a physician. Medical education is expensive and requires at least a decade of special study. Many of our members have talented boys and girls, and this month the Journal is featuring a list of scholarships that might lessen the financial burden on an expensive career.

The admiration of patients for the skill and goodness of their family physician will often lead them to inquire about means of securing financial aid so their children can pursue the study of medicine. This month's reference sheet should assist the physician in providing his patients with such information.

Serious professional losses

The glamour of the medical profession and the reputation of the physician have suffered during the past two decades. One of the most serious side reactions of this loss of prestige has been its adverse influence on the scientific-minded young men and women. Our population has increased; yet the number of applicants to medical schools has decreased.

There is evidence also that we no longer are attracting the better students. Dr. I. S. Ravdin was quoted recently as saying, "Where is the doctor coming from to treat patients?" And, "Many of our best young people are not going into medicine." Many bright students find other sciences more attractive. In addition, it is easier to obtain scholarships and loans for graduate study in physics and chemistry leading to the Ph.D. degree than in medicine.

Those who go into medicine face years of study and training, and many are beset by financial difficulties. Others are deterred by the adverse criticism of the medical profession from Capitol Hill and elsewhere.

This loss of students is serious because it strikes at the very foundation of the profession. It may be that those who have screamed the loudest for sweeping reforms in the practice of medicine will be forced to accept a second-rate team of their own making.

K-fusion

The Journal's advertising revenue is down considerably due to a marked curtailment of national pharmaceutical advertising. The drug firms have tightened their purse strings since Kefauver investigated the industry. There is a good possibility that the loss in revenue to the society may cost each member $5 by the end of the year — thanks to the senator from Tennessee. This is chicken feed compared to what it is costing every taxpayer to run these investigations that vary from the ridiculous to the sublime.

We know little about the motives behind congressional investigations, how the witnesses are selected, and whether the government is trying to uncover the truth or prove a preconceived idea. In dealing with costs of drugs, the committee failed to question the merchandizer, the pharmacist who sells drugs to the public. The price of the same prescription may vary considerably at different drug stores, depending upon their overhead and business acuity.

But politicians think in terms of votes: There are more drug stores than pharmaceutical companies, and the corner druggist is closer to the public.

Morris Fishbein had the following to say in an editorial, "Kefauver's Drug Bill," in Medical World News, May 26:

"The height of folly is the proposal in the Kefauver doctrine that manufacturers be required to provide physicians 'with clearer, better, and additional information on the bad as well as the good effects of drugs.' The Secretary of the Department of Health, Education and Welfare would be required to mail regularly to all physicians brochures containing lists of drugs potentially dangerous or harmful. It is also suggested that 'he may include in that list such information relating to those dangers or harmful effects as the Secretary may consider in the best interest of public health.'

"Finally, the legislation says, 'the Secretary shall have authority to determine the name of any drug as he shall find necessary or desirable in the interest of usefulness and simplicity.' This shall thereafter be the official name of that drug. Furthermore, 'no official name shall be given to any drug product which is a combination of two or more drugs.' One might as well give the Secretary of HEW the responsibility for naming all the babies born in the United States."

Sometimes when I consider what tremendous consequences come from little things—a chance word, a tap on the shoulder, or a penny dropped on a news-stand — I am tempted to think . . . there are no little things. — *Bruce Barton*

AT THE EDITOR'S DESK

Saving the Tax Dollar

The private psychiatric hospital is an important asset not generally appreciated by the public. Such hospitals are saving Illinois taxpayers an estimated sum of $10 million per year in direct costs. Mr. Morris B. Squire, administrator, recently called attention to the fact that Forest Hospital in Des Plaines cared for more than 200 new patients in the last three months of 1960. "We admitted more patients during that period than one state hospital which has a capacity of more than 3,000 beds compared with our 90." This turnover of patients is based on the highly individualized attention given in private institutions.

The Yellow Pages

According to Advertising News, a bill signed into law by Governor Rockefeller prohibits physicians from advertising in telephone directories, magazines or on television or "by means of flamboyant or glaring or flickering signs." The legislature indicated it passed the law to hit at advertising by plastic surgeons in the Yellow Pages.

The Complete Pre-fab Office

The Mebuco Corporation of Mansfield, Ohio, one of our latest advertisers, has introduced a new concept in office buildings. They are manufacturing completely packaged medical office buildings that can be delivered completely equipped and furnished to the purchaser's site within a few weeks from the date of order.

The basic building unit contains over 900 square feet of floor space with prices beginning at $20,700. It contains a surprising amount of built-in equipment including 43 built-in cabinets, air conditioning, and separate EKG circuits.

Hepatitis on the Decline

A significant decline in the number of cases of hepatitis was reported in the northern and eastern states, while a number of states in the South Atlantic, East and West South Central districts showed minimal to moderate increases.

A New Home

The Michigan State Medical Society has just completed their new headquarters building. It was designed especially for the medical associ-



ation by the internationally famous architect, Minoru Yamasaki, of Birmingham. It has three times the floor space of the former office building located in downtown Lansing.

What's New

There has been a noticeable scarcity of news items on new drug products. Instead we are receiving two to three times as many releases on instruments, office equipment, and electronic devices.

The Espey Manufacturing and Electronics Corporation has introduced a new and revolutionary electronic laryngoscope called the laryngauto-vibrascope. According to the manufacturers, it is a significant contribution to medical diagnosis in a particularly difficult area.

It is unique in that it employs the stroboscopic principle of freezing motion, which in turn permits the analytical examination of the vibrating vocal cords. The physician is thus permitted time for a detailed and clear study of the vocal cords and other areas in the throat.



Tine test unit

A new technique for administering the tuberculin test was described recently by several investigators, including Sol Roy Rosenthal, director of Tuberculosis Prevention Research, of MTS in Chicago. It is known as the Tine Test because the tuberculin is dried on steel prongs, or tines, held on the end of a plastic cylinder, and pressed into the skin. The unit is then discarded. This disposable, sterile unit was developed by Lederle Laboratories.

A new Dutch machine known as the Godart Pulmometer is basically a spirometer with a 7 liter bell. It is capable of gauging and determining the vital capacity, timed vital capacity, and maximum breathing capacity from a single forced breath.

A new abduction splint is now in production at the Fuzere' Manufacturing Company that can be used for treating congenital hip dysplasia and, in certain cases, congenital hip dislocation.

It is made of acrylic plastic material and weighs only a pound. Clear x-rays can be made while wearing the splint because of its radiotransluceney.

It allows bathing and diaper-changing without removal and is available in standard sizes for most children.

Conflicting Voices

A startling newspaper report on methotrexate in cancer chemotherapy quoted Surgeon General Luther Terry. It was in sharp contrast to the following Lederle news release that appeared a few days later: "Some of the interpretations of the Surgeon General's remarks have unfortunately given rise to overoptimism in some quarters. The two points most often misinterpreted are:

1. Methotrexate's ability to bring about five-year remissions: such results are limited to choriocarcinoma as reported recently — and only in some cases of this relatively rare form of cancer.

How's Business?

Publishers Printing Company (April) had the following to say about business: "*Note of warning on the stock market* from brokers and investment advisers: They are increasingly concerned about the mounting speculation by the public — the little man — who is jumping in with both feet, often buying risky shares.

"*The experts still see increases ahead* — especially as business improves. But stock prices are outstripping earnings and a shake-out could hurt many.

"*The boom in farm land now seems to be over* . . . for the time being, anyway. Indeed, the Department of Agriculture reports that land values fell in 1960."

Plastic Surgery for Rare Defect

A rare birth defect was reported recently by a Mayo Clinic plastic surgeon. A three year old girl had two completely formed noses. The outer nostrils of each nose were well developed, whereas the inner nostrils were smaller in size. Dr. John B. Erich removed the two middle nostrils, brought the nasal bones closer together in order to make the nose narrowed, and created a single nose with the remaining nostrils. A double thickness graft of skin from the child's abdomen was used to improve the contour.

"Little New under the Sun"

The May 26 issue of Time Magazine had a story on the use of cadaver blood for transfusion in the United States. It was used by two Pontiac pathologists, Jack Kevorkian and Glenn W. Blysma, following the patterns established in Russia.

The pathologists were of the opinion that they were applying the Russian method for the first time in the United States, but learned from a recent Bulletin of the American Association of Blood Banks "that as long ago as

1935 Surgeon Leonard L. Charpier had used a similar technique in a Chicago suburb. Dr. Charpier kept the work secret and died without writing up his records. But he was responsible for about 35 cadaver-blood transfusions in two years. Then the modern system of blood banking, which permits blood to be stored for three weeks without deterioration, was developed."

Good Old Alumni

The Minnesota Medical Alumni Association is conducting a drive for a new medical student center at their alma mater. It will include lunching and snack facilities; a lounging area; racks and lockers for temporary storage of textbooks, valuable instruments, and other material required in medical training.

It will also house a ready-room for advanced clinical medical students assigned to the medical school's new comprehensive clinical program. The students will await calls and referrals and write case reports in this area. Most physicians will read this with nostalgia. The Gophers make good alumni.

Wonderland

You can expect anything when Madison Avenue takes over your advertising. A good example is a news release on the new antiseptic anesthetic sprays, "Their miraculous action which checks infection as it stops the scream is like something out of wonderland." Oh, brother! The spray contains Xylocaine®, benzalkonium chloride, and hexachlorophene.

Pharmaceuticals

Coly-Mycin Injectable is Warner-Chilcott's new antibiotic for severe and chronic resistant urinary tract infections caused mainly by *Pseudomonas aeruginosa*. It is said also to be effective against *Escherichia coli, Aerobacter aerogenes, Klebsiella pneumoniae*, and *Brucella*. According to the manufacturers, Coly-Mycin Injectable is devoid of serious side effects at recommended dosages. It should be administered intramuscularly only.

The manufacturers report also that an increasing number of reports in medical literature emphasize that severe bacterial infections and deaths caused by *Pseudomonas aeruginosa* are on the upswing.

The Rystan Company introduced Buclamase several weeks ago. It is a buccal tablet containing 10 mg. of the enzyme alpha-amylase. The manufacturer is optimistic and claims that the product will inhibit or resolve inflammation, edema, or pain due to trauma or infection, will depress inflammatory reactions associated with allergic states, and will help overcome chronic inflammation associated with connective tissue disorders. This is a big order for any enzyme.

Many pharmaceutical companies are in the veterinary field and are doing a booming business. Turkey producers will be able to have Amprol incorporated in poult rations for the prevention of coccidiosis during the 1962 season. The unprecedented demand for Amprol is being met by Merck through a multimillion dollar program to expand production facilities.

A new dusting powder containing diphemanil methylsufate (Prantal) (Schering) is reported to be of value in hyperhidrosis of the feet. The powder is dusted into shoes and socks once daily. Ventilated shoes and socks of cotton should be worn also.

Betamethasone (Celestone) is Schering's latest steroid. It carries the claim of all newcomers in this field: "exerts its antirheumatic and anti-inflammatory activity at lower dosages than other steroids available. . . ."

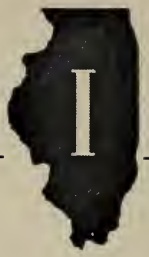
Hospital Room Cooling

General Electric offers a new portable air conditioner that rolls easily from room to room and can be adjusted to fit windows at varying heights. It eliminates installation expense and the need for a cooling unit in every hospital room. It is secured to the "porta-cart's" easy-to-slide carriage and never has to be removed from it.

The Tale That Wags the Dog

According to Science News Letter, puppies will grow up afraid of and unwilling to socialize with humans when they are not handled before they are 14 weeks old.

ANNOUNCEMENTS



Annual otolaryngologic assembly

The University of Illinois College of Medicine's department of otolaryngology is offering an intensive postgraduate basic and clinical program for practicing otolaryngologists September 23-30. Directed by Dr. Emanuel M. Skolnik, it offers week-long day and evening sessions featuring a review of basic morphologic features by Drs. Maurice F. Snitman and Frederic J. Pollock. Laboratory demonstrations, dissection and prosection, luncheon chats, and panel programs on otologic and reconstructive surgery and tumors of the head and neck comprise the daily programs.

Interested physicians should write the Department of Otolaryngology, University of Illinois College of Medicine, 1853 W. Polk St., Chicago 12.

World medical equipment on view

The latest in medical and electronic equipment from all areas of the world will be on display at the 1961 Chicago International Trade Fair at McCormick Place, July 25 through August 10.

A complete line of Austrian electrocardiographs will be exhibited in the Austria Pavilion. Manufactured by Ing. Wolfgang van Karajan, Salzburg, they include many features not regularly found on American models. Among the units will be the world's lightest portable electrocardiograph, a second portable device incorporating the characteristics of console models, and a research apparatus which allows for direct, photographic and audio recording, plus three oscilloscope tubes for continuous observation of the patient's reaction.

More than 25 countries will show their goods and services in national pavilions, and scores of individual exhibitors will display a wide variety of products from every corner of the earth. Sixty nations, including the USA, will be represented by products at the Fair, which will be held simultaneously with the Inter-American Industries and Chicago World Marketing Conferences.

Medical photographers' annual Meeting

The Biological Photographic Association will hold its annual meeting August 21-24 in Chicago's Hotel Knickerbocker. The only professional society in North America dedicated to the advancement of the skills of medical and biological photography, it has a world-wide membership of physicians, medical editors, educators, and institutional staff photographers in the fields of medicine and other biological sciences.

Mervin W. LaRue, medical motion picture producer and audiovisual consultant to the medical profession, will be general chairman. Co-chairmen will be Charles Lindsay, Loyola University's Stritch School of Medicine, and Albert Levin, Cook County Hospital.

Vacation ideas

Vacationing physicians may wish to enhance their trips this summer by taking in one of the following:

The new Confederate Medical Exhibit in Richmond, Va. offers an interesting stopover for those passing through the South this summer. It opens to the public in late July and is sponsored jointly by the Virginia Civil War Commission and the Richmond Academy of Medicine. Located in the Academy's building, the air-conditioned exhibit depicts military medicine in

Virginia during 1861-65. Across the street from it is the Confederate Museum, housed in the wartime home of President Jefferson Davis. All aspects of Confederate medical care are shown by pictures, models, reports, charts, surgical equipment, and wartime books and may be seen during the summer months of 1961-65. The Medical College of Virginia, the University of Virginia, and State dental and pharmaceutical groups have helped arrange the exhibits, including a display by the U. S. Army Medical Service.

The Law-Science Academy of America is holding a nine-week summer instructional program on "Legal Medicine and Elements of Medicolegal Litigation" June 12 to August 11 in the Law-Science Academy Hall, Crested Butte, Colo. The course is directed toward lawyers and physicians interested in personal injury problems. Dr. Hubert W. Smith is director and moderator.

Physicians are invited to attend. Each week a different course is held which relates to those preceding and following it. For further information write Dr. Smith, Chancellor, Law-Science Academy of America, Law-Science Academy Hall, Crested Butte, Colorado.

Course on law for physicians

The Board of Trustees of the American Medical Association and the home-study department of the University of Chicago have entered a joint project to prepare and present a home study course on Legal Problems in the Practice of Medicine. The course is designed to give the physician an opportunity to acquire some knowledge of the principles and operation of American law as well as the interrelationships of law and medicine. It is intended to enable physicians to avoid situations which might lead to medical professional liability actions against them and to help them recognize legal situations that might require the aid of an attorney.

Tuition is $35, exclusive of texts and selected reading material which cost about $25. Assignments should be mailed to an instructor of the home-study department for evaluation and comment and may be submitted by the registrant at his convenience within the year's span of the course. The course is also adaptable for group study.

For further details contact Desk LSE, Home-Study Department, the University of Chicago, 60th at Dorchester, Chicago 37.

Board examination schedule

The next scheduled Part I (written) examination of the American Board of Obstetrics and Gynecology will be held in various cities of the United States, Canada, and military centers outside the Continental U.S. on Friday, January 5, 1962.

Case reports are no longer required by the Board to complete the Part I examination. Each applicant and candidate for examination is required to submit a duplicate certified typewritten list of all patients admitted to or dismissed from each hospital where he or she has practiced during the year preceding application or request for examination. Obstetrical and gynecological patients are to be listed separately, and lists must conform in all details with the sample format furnished by the Office of the Secretary-Treasurer upon request. Candidates are no longer required to bring a duplicate list of admissions to the Part II examinations.

The next scheduled Part II examination (oral and pathology) with be held at the Edgewater Beach Hotel, Chicago, April 9-14, 1962.

For current bulletins write the Office of the Secretary-Treasurer, 2105 Adelbert Rd., Cleveland 6.

Pennsylvania M.D.'s, labor leaders Form joint committee

The Pennsylvania Medical Society, in an effort to improve its relations with organized labor, recently formed a permanent liaison committee of five representatives of labor and five of medicine at the state level for the purpose of discussing problems of medical care concerning both groups. The organization of similar liaison groups are also being urged at the county society level.

One of the first of its kind in the country, the committee had its initial meeting in April and will continue to meet frequently to discuss and seek solutions to mutual problems affecting the quality, distribution, and cost of medical care. The committee is a result of a pioneering conference on health care sponsored last November by

the society and attended by 50 representatives of organized labor and 50 from organized medicine in Pennsylvania.

1961 Redbook for pediatricians Released

The American Academy of Pediatrics has published the 1961 edition of the Redbook—Report of the Committee on the Control of Infectious Diseases. The manual was completely rewritten from previous editions and expanded to cover more subjects, such as drug dosages, serum reactions, newer viral diseases, and the latest thoughts on immunizations.

Part I discusses immunization procedures, giving precautions and contra-indications, active and passive procedures, and special requirements for foreign travel; Part II reports summaries of infectious diseases, from adenoviral infections through mononucleosis to tularemia. A variety of tables are included in the book, which is based on the scientific finding of pediatricians, the pharmaceutical industry, and government agencies.

SK&F grant to Vestermark Fellowships

The Smith Kline & French Foundation has made an additional grant of $10,000 for the continuance of the American Psychiatric Association's Vestermark Fellowships, under which selected medical students may expand their psychiatric knowledge.

The fellowships, named for the late Dr. Seymour D. Vestermark for his outstanding contributions to psychiatric training, provide medical students with the opportunity for full-time summer work in public mental hospitals.

The SK&F Foundation Fellowship Committee stated it was "particularly anxious" to receive applications from hospitals which have not previously participated in the program. Applications should be addressed to the SK&F Awards Committee at the APA Central Office, 1700 18th St. N.W., Washington 9, D.C.

Recruiting the physician

The American Academy of General Practice has launched Project More, a program intended to forestall a "mountingly-serious physician shortage and help block the rising cost of medical care." The AAGP feels that the nation must have more physicians if the burgeoning U.S. population is to receive full benefit from the advances in scientific medicine already achieved and those yet to come from the research laboratories. Fundamental to this system is an effective ratio of physicians to population, and a balanced distribution of practicing family physicians.

The AAGP has given its support to the segment of President Kennedy's health scheme which concerns federal aid to construction of school facilities because of the fast-approaching "physician gap" and the huge sums of money for education required to reverse it.

The academy program will be publicized at both community and national levels by various communication techniques such as radio and TV interviews and the medical press. Pilot programs in several communities will be set up and followed through on mechanics to get the program rolling.

The drive is backed by the belief that if more emphasis were placed on the importance of family practice during the undergraduate years, a correspondingly greater number of students would choose family practice as a career, thereby helping to re-establish the balance within the physician force.

Communication Institute Innovations

The Institute for Advancement of Medical Communication, headquartered in New York City, has formed a Scientific Council to guide its program of research, development, and training aimed at improving communication among biomedical scientists and health science practitioners. The council consists of 20 scientists and educators representing many of the disciplines and specialties contributing to, and using, the expanding pool of biomedical information.

The institute also opened a Washington, D.C. branch, headed by Isaac D. Welt, Ph.D., its associate director. Dr. Welt was formerly with the National Academy of Sciences - National Research Council, where he was director of the Cardiovascular Literature Project. This project

will be continued under the auspices of the Institute.

New medical films

A number of new medical films have been released which may serve as program material for county medical societies or by physicians requested to speak before lay groups. A group of those which have come to our attention follows.

A 34-minute color film, "Bronchitis and Bronchiectasis: Differentiation for Treatment," has been made by medical specialists at the Veterans Administration Hospital in Oteen, North Carolina. The movie uses case studies of two patients with chronic bronchitis and bronchiectasis and concludes that therapeutic use of antibiotics is indicated for bronchitis, while medical treatment and surgery has an 85 per cent cure rate in bronchiectasis. Medical personnel and patients at the VA Hospital are featured, and various diagnostic techniques and equipment, such as cinefluorography or "x-ray movies," are used to identify the diseases.

The film is produced by Campus Film Productions Inc., New York, and sponsored by Pfizer Laboratories, a division of Chas. Pfizer & Co., Inc. It will be distributed through Pfizer's medical film library to physicians, medical schools, and medical organizations.

A series of 16-mm. color and sound motion pictures about various aspects of physical diagnosis is available for rental or purchase from Wayne State University College of Medicine. The project was sponsored by CIBA Pharmaceutical Products Inc., although none of its products are mentioned. Requests for showing or purchase should be sent to the Audio-Visual Utilization Center, Wayne State University, Detriot 2.

"The Silent Witness" is a 27-minute motion picture dealing with chemical tests for intoxication. The "silent witness" of the movie's title is one of several commercial devices which effectively measure the alcohol in the breath. Questions and answers about alcoholism tests are discussed in the film's story of a drinking driver who is arrested, tested, and tried.

The movie was produced by the William S. Merrell Company, Division of Richardson-Merrell Inc.) in cooperation with the American Medical Association and the American Bar Association and is the sixth in a series of Merrell-AMA films on medicolegal subjects.

Prints are available through the American Medical Association's Film Library, Chicago, or the William S. Merrell Company, Division of Richardson-Merrell Inc., Cincinnati 15.

Clinics for crippled children

August	2	Alton (Rheumatic Fever), Alton Memorial Hospital
August	2	Hinsdale, Hinsdale Sanitarium
August	3	Macomb, District Hospital
August	3	Litchfield, Madison Park School
August	4	Chicago Heights (Cardiac), St. James Hospital
August	8	East St. Louis, St. Mary's Hospital
August	8	Peoria, Children's Hospital
August	9	Champaign-Urbana, McKinley Hospital
August	10	Springfield, St. John's Hospital
August	11	Evanston, St. Francis Hospital
August	15	Belleville, St. Elizabeth's Hospital
August	16	Chicago Heights (General), St. James Hospital
August	17	Elmhurst (Cardiac), Memorial Hospital of DuPage County
August	17	Rockford, Rockford Memorial Hospital
August	22	Effingham (Rheumatic Fever), St. Anthony Memorial Hospital
August	22	Peoria, Children's Hospital
August	23	Elgin, Sherman Hospital
August	24	Bloomington (A.M. - General), St. Joseph's Hospital

If the spirit of business adventure is killed, this country will cease to hold the foremost position in the world. — *Andrew W. Mellon*

Annual Meeting 1961

On Location

President Elect Dr. Edwin S. Hamilton and his wife (left) were guests of President H. Close Hesseltine and his wife at the president's cocktail party preceding the annual banquet.





(Left) Mrs. Frances C. Zimmer, executive assistant, at home with silver coffee set, gift of the Society, on her 25th anniversary of service. (Below) The Management Seminar Panel speakers were secretaries of county medical societies: (left to right) Howard N. Schultz, Peoria County, Dr. Allison L. Burdick, Chicago Medical Society, Floyd E. Tarbert, Winnebago County, Mr. Robert L. Richards, executive administrator and moderator, Dr. Charles Lang, DuPage County. David W. Meister, Peoria County, and Aubrey Gates, AMA, were not present for the picture.



Two old-timers, Dr. Andy Hall, (below, right) perennial chairman of the 50-Year Club banquet, and Dr. William E. Carnahan, Macomb, Ill. General Practitioner for 1960, have a few private words with each other. *(Associated Press Photo)*



The Hon. Derwood G. Hall, M.D. (R.) Rep. 7th Congressional District, Mo. spoke on physicians' citizenship responsibilities at the Management luncheon.





(Above) One of the best attended meetings (150) was the Symposium on Neurology and Psychiatry with Dr. Louis D. Boshes, Chicago, (right) presiding. Panel members (left to right), all of Chicago, are Drs. E. E. Gordon, Oscar Sugar, and I. C. Sherman.



Dr. John B. Reckless, Durham, N. C., after delivering the Camp Memorial Lecture, talked briefly with Millie Camp Roselle.



The Drs. Rolnick, H. C. (left) and son Donald (right) are both urologists and practice together. Both attended the 50-Year Club dinner.



Dr. John O. Cletcher of Tuscola (left, above) attended his forty-ninth consecutive annual meeting of the Society this year, and Dr. W. L. Daugherty, Hutsonville, was being initiated to his first.





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Candid Camera



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1. Two grand old men of Chicago Medicine get tickets to 50-Year Club Banquet: Dr. Archibald Hoyne (center) and Dr. and Mrs. Walter H. Theobald.

2. Weary and waiting. Mrs. Frank P. Thometz, Chicago, and grandson Martin.

3. A meeting at the Registration Desk.

4. Medical students look over exhibit. Leon Asadourian and Joseph Daw from University of Illinois.

5. Dr. Henry A. Harlman, Kankakee, inspects American Sterilizer's power-operated table.

6. Dr. S. W. Marwitz, Chicago, checks his program.



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NEWS of the STATE



County

Cook

Appointments

Dr. Vincent J. Collins has been appointed chairman of the department of anesthesiology at Cook County Hospital. He was recently acting director of the department of anesthesiology at the Bellevue Medical Center and associate professor of anesthesiology at New York University Medical College. He is secretary of the Section on Anesthesiology of the American Medical Association.

John M. Stagle, assistant director of Passavant Memorial Hospital for the past eight years, is the new director of the hospital. He succeeds John N. Hatfield, who is retiring after eight years as director to devote full time to his hospital consulting practice.

The Chicago Medical School has appointed retired Navy Commander David N. Goldenson, who was officer-in-charge of Navy recruiting in the Chicago district during World War II, to the newly created post of vice president for development.

He comes to head the school's development program during a new period of expansion; the almost completed $4,135,000 Institute for Medical Research is the first building on the school's West Side Medical Center campus, and several additional ones, including a College of Physicians and Surgeons structure with an expanded enrollment to take the place of the present medical school, are planned for the future.

Col. Charles P. Ward has been made Medical Advisor to the United States Military Mission with the Iranian Army. He received the Fifth Army Certificate of Achievement in a farewell ceremony at Fifth Army Headquarters, Chicago, where he had been Commanding Officer of the U. S. Army Dispensary since 1956. Previously, he had been Deputy Commander of American General Hospital, Fort Lewis, Wash. Before departing for Iran with his wife in June he attended four-week sessions of the Military Assistance Institute in Washington, D. C.

Societies announce 1961-62 officers

Dr. Franklin Lounsbury, assistant professor of surgery, Northwestern University Medical School, became president of the medical staff of Passavant Memorial Hospital, succeeding Dr. Edmund A. Gorvett, assistant professor of medicine.

Dr. Lounsbury is a fellow of the American College of Surgeons, a diplomate of the American Board of Surgery, and a member of the Central Surgical Association and the Chicago Surgical Society.

Dr. R. Burns Lewis, assistant professor of radiology at Northwestern, was named president elect of the Passavant staff, and Dr. Augusta Webster, professor of obstetrics and gynecology, was re-elected secretary.

Dr. Thomas J. Coogan, Chicago, was elected to a second term as president of the medical staff of Presbyterian-St. Luke's Hospital. Also re-elected were Dr. Edward N. Irons, Chicago, vice president; Dr. Frederic A. dePeyster, Winnetka, secretary; and Dr. Philip N. Jones, Kenilworth, treasurer.

Dr. Russell E. Elmer has been named to his second term as president of the medical staff of Swedish Covenant Hospital. Dr. E. A. Millar was re-elected vice president, and Dr. James B. McCormick was re-elected secretary-treasurer.

The Chicago Pediatric Society elected its 1961-62 officers May 16. They are Drs. James A. Conner, Hinsdale, president; I. Pat Bronstein, Chicago, vice president; Joseph R. Christian, River Forest, secretary; Harry L. Faulkner, treasurer; and Howard S. Traisman, editor. Elected to the executive committee were Drs. Noel G. Shaw, Raymond F. Grissom, and Matthew M. Steiner.

The newly elected officers of the Chicago Neurological Society are Dr. Harold R. Oberhill, president; Dr. Louis D. Boshes, vice president; Dr. Sidney Schulman, secretary-treasurer; and Dr. Ernst Haase, councilor.

The officers of the Chicago Psychoanalytic Society for 1961-62 are Drs. Gerhard Piers, president; Frances Hannett, president elect; Samuel D. Lipton, secretary; Philip F. D. Seitz, treasurer; Herman M. Serota, representative to the Executive Council; and Joseph G. Kepecs, alternate representative.

The Chicago Laryngological and Otological Society's 1961-62 officers are Drs. Linden J. Wallner, president; Bernard M. Cohen, vice president; and John J. Ballenger, secretary-treasurer.

Dr. Howard Wakefield, Chicago, was re-elected a Regent of the American College of Physicians at its annual meeting in Bal Harbour, Fla., in May.

Honors accorded

The University of Chicago School of Medicine has named John R. Green of San Francisco, a student at the University, the recipient of its annual Borden Award. A $500 check was given him at the Medical Alumni Reunion Banquet on June 8. His name will also be inscribed on a permanent plaque at the school.

Mr. Green studied the mechanism of action of an enzyme found in beef liver and devised a method of crystallizing the enzyme. He will intern at the University of Washington Hospital, Seattle, and plans to pursue a career in biochemical research.

Dr. Max K. Horwitt, associate professor of biological chemistry at the University of Illinois, has been named winner of the 1961 Osborne and Mendel Award for outstanding accomplishments in the field of nutrition research. An inscribed scroll and $1,000 was presented at the annual meeting of the American Institute of Nutrition in Atlantic City, N. J. Dr. Horwitt has recently been working on vitamin E and fatty acid metabolism and the ability of diet to change the fat composition of microcellular constituents. He has been director of the Biochemical Research Laboratory, now the L. B. Mendel Research Laboratory, at Elgin State Hospital for the past twenty-three years.

Students of the University of Illinois College of Medicine awarded six faculty members "golden apples" at recent ceremonies in the Chicago Illini Union. Each year the apples go to instructors selected by the students on the basis of the greatest degree of helpfulness, excellency, and interest in their instruction.

The senior class honored Dr. Eric Oldberg, head of the department of neurology and neurosurgery, and Dr. Max M. Montgomery, professor of medicine. Junior class awards went to Dr. Nat E. Smith, assistant professor of medicine, and Dr. Ben W. Lichtenstein, clinical professor of neurology.

The sophmore selection was Dr. Eli Tobias, assistant in neurology and neurosurgery, and the freshmen named Dr. Terrell C. Myers, associate professor of biological chemistry.

Officially titled the Raymond B. Allen Instructorship Award, it was established as a means of expressing appreciation to the faculty members who sincerely endeavor to further medical education, and the instructors so honored have their names inscribed on a permanent plaque hung in the Union.

Dr. George H. Conner, resident in otolaryngology at the University of Illinois College of Medicine, was the winner of the Norval H. Pierce Award in Otolaryngology for 1961. The award of $100 and a certificate was given by an anonymous donor for the best essay by a resident in

training in otolaryngology and is presented by the Chicago Laryngological and Otological Society.

Dr. Thomas A. Garrett, medical director of Baxter Laboratories, Inc. in Morton Grove, is one of five who received the first Alumni Medals of the Alumni Association of Villanova University, Villanova, Pa., at the association's annual banquet in June.

Dr. Howard J. Shaughnessy, head of the department of public health of the University of Illinois College of Medicine, was presented the scroll and plaque of the Illinois Public Health Association's Award of Merit for 1960. Dr. Shaughnessy, a past president of IPHA, is also chief of the Division of Laboratories of the Illinois Department of Public Health.

Dr. Grove new associate dean at Illinois

Dr. William J. Grove, associate professor of surgery at the University of Illinois since 1954, became associate dean of the university on July 1. He succeeds Dr. William F. Kellow, who left to become dean of the Hahnemann Medical College, Philadelphia.

Dr. Grove is also on the staff of Presbyterian-St. Luke's Hospital and received the "golden apple" as outstanding instructor in 1959 by the junior class of the University of Illinois Medical School.

Dr. Kellow is a board member of the Tuberculosis Institute of Chicago and Cook County and formerly was chief of medicine at Beale, Cal., Air Force Base Hospital.

Cancer research on Africans

Dr. Stephen Rothman, professor emeritus in the department of medicine at the University of Chicago, joined 15 other physicians from all over the world at Kampala, Uganda, East Africa from May 22 through May 27 to study Kaposi's sarcoma. The meeting, sponsored by the International Union Against Cancer, hoped to discover why a cancer so rare in the United States is 200 times more prevalant in Uganda.

Dr. Rothman, a staff member of the Argonne Cancer Research Hospital, operated by the University for the Atomic Energy Commission, was invited to participate by officials of the National Institute of Health and the National Academy of Sciences. He and the other international experts heard Uganda physicians reports of case histories, examined Kaposi patients, and investigated racial, tribal, infectious, nutritional, and climate factors which might offer new clues to the cause of the disease.

The International Union's Committee on Geographic Pathology first found Kaposi's sarcoma among Bantu tribesmen about 10 years ago, and while only eight cases of it have been noted in the past 15 years by the Cancer Registry at the University of Chicago, physicians in Uganda report that 10 to 12 per cent of all malignancies in some areas of equatorial Africa are of the Kaposi variety. Most U. S. reports have been on adult cases, but in Africa this disease has also been found in children, with first symptoms appearing in the lymph nodes.

Dr. Rothman lectured in Capetown, South Africa prior to his arrival in Kampala, and before returning to the U. S. addressed physicians at the University of Athens, Greece.

Grants to support studies

The Dyslexia Memorial Institute of Northwestern University Medical School has been given a two-year grant of $51,505 from the Illinois Department of Public Welfare for research on the types of reading difficulties and methods of treating them.

Since its inception in 1938, the institute, directed by Dr. George E. Park, has successfully aided 75 per cent of the more than 1,000 retarded readers under its guidance. Its staff of two physicians, a speech correctionist, a case worker, two psychiatrists, five psychologists, and three teachers examine each child and report their findings and advice to the parents, and with their consent, to the family doctor and the school.

Five grants totaling $71,359 for cancer and heart research have been awarded members of the medical staff of Presbyterian-St. Luke's Hospital by the Department of Health, Education, and Welfare and the American Cancer Society, Illinois Division.

Dr. Frances E. Knock, adjunct in surgery, and Dr. Edward J. Beattie, Jr., chairman of the division of surgery, received $29,950 from HEW for studies of cancer cell cultures as influenced by cancer treatment agents. Dr. Knock also

received a $9,450 grant from the American Cancer Society to maintain a cytogenerator.

Other HEW grants were $17,664 to Dr. Frank R. Hendrickson, director of radiation therapy, to study the effects of radiation upon the growth cycle of the individual cell; $6,238 to Drs. Steven G. Economou, D. M. Buckner, and J. Ellenby to study leakage of anticancer agents from the cancerous area of the body while isolated for perfusion with curative agents; and $8,057 to Drs. Beattie and Economou to study the circulation of blood before, during, and after repair of experimentally produced aneurysms of the heart.

Presbyterian-St. Luke's Hospital will devote one million dollars to research during the fiscal year out of its annual 16 million dollar budget.

The medical staff at the hospital is required by its by-laws to devote a substantial portion of time to nonremunerative service, which may be teaching, research, administrative work, or public service.

University diagnostic center dedicated

The new $1,480,000 Goldblatt Pavilion of the University of Chicago was dedicated June 1 at a dinner in the Great Hall of the Pick-Congress Hotel, Chicago. Dr. Jonas Salk, professor of medicine at the University of Pittsburgh, spoke on "The Biological Basis of Disease and Behavior."

The three-story building linking Chicago Lying-In Hospital and Billings Hospital will serve as the diagnostic center for the University's medical facilities.

Illini to build laboratory

The University of Illinois will construct an $800,000 laboratory on the Urbana Campus to facilitate research in lipid metabolism, the earlier neglect of which has hampered operational programs aimed at the control and eradication of degenerative diseases.

Currently a training program in lipid metabolism and nutrition is being carried out at the university under the direction of Professor F. A. Kummerow of the department of food chemistry.

Madison

Dr. Edward H. Reinhard, professor of medicine, Washington University School of Medicine, spoke on "Current Chemotherapy of Cancer" at the June 6 meeting of the Madison County Medical Society in East Alton.

Vermilion

Dr. Hiram E. Ross, Hinsdale, received the fifty year pin and emblem of the Illinois State Medical Society from Dr. Harlan English at the May meeting of the Vermilion County Medical Society. His many accomplishments, activities, and services during his fifty years of medicine were cited, and he was given a rising vote of appreciation by the society.

General

Old-timers have their day

The 50-Year Club held its annual luncheon May 16 with 161 members and guests on hand to see the awarding of framed certificates of membership and lapel emblems to new members. Dr. Andy Hall, chairman since 1938, assisted by Dr. E. A. Piszczek, chairman of the Council, made the presentations to the 23 new members present. Twenty-five downstate members and 16 from the Chicago area who were not in attendence had already received their membership insignia or were sent them by mail. Those physicians from Chicago taken into the Club at the meeting were

Paul G. Dick	Samuel M. Morwitz
Edward F. Fox	John B. Nardi
Murray M. Fuchsmann	Harry C. Rolnick
Franklin R. Huckin	Abel P. M. Sandahl
David J. Jones	Otto H. Schulz
Boleslasu K. Lazarski	James Shaynin
Adolph M. Magnus	Don C. Sutton
Franklin B. McCarty	Walter H. Theobald

Others there to receive their certificates and pins were Drs.

Harry J. Dooley and John J. Sprafka, Oak Park	Martin H. Merbitz, McKinney, Texas
Frank H. Lally, Blue Island	James Patejdl, Palos Park
	Robert L. Reynolds, Franklin Park

Hugh M. Leaf, Elmwood Park

Dr. Percival Bailey was the luncheon speaker and gave an informal talk containing "many

wild yarns on Dr. Hall's earlier days in Mt. Vernon." Dr. Bailey was himself delivered by Dr. Hall.

Dr. Hall had a surprise during the luncheon when Dr. H. Close Hesseltine, ISMS president, gave him the American Medical Association's gold medallion for America's Outstanding General Practitioner of the Year. When the AMA learned that Dr. Hall had lost the first one awarded him in 1949, it ordered another as a replacement.

Mrs. Zimmer honored for 25 years with Society

Mrs. Frances Zimmer, executive assistant of the Illinois State Medical Society, received a silver tray and tea service in commemoration of her twenty-five years with the Society at the May 16 evening session of the House of Delegates during the annual meeting at the Sherman Hotel. Dr. Edwin S. Hamilton, new president of the Society, was chosen to make the presentation because he is the only member of the present Council who was a councilor (11th district) when Mrs. Zimmer first joined the staff.

In January 1936 she took a temporary job at the Society's main offices in Monmouth; her stay lengthened into 25 years, during which she took on any and every task that needed doing. There were many such duties since the only other person in the office when she began was Mrs. Elizabeth Wayland, who later left after 19 years with the Society. Mrs. Zimmer remained at the Monmouth office until May 1960 when she came to the Society's new headquarters at 360 N. Michigan Ave., Chicago.

Ob-Gyn certifications to Illinois physicians

The Illinois physicians certified as specialists by the American Board of Obstetrics and Gynecology in April are as follows: Drs. Adnan B. Baydown, Clarence A. Lathrop, Paul E. Lawler, Robert B. Pildes, Ference H. Samos, Hans Wachtel, and Jasper F. Williams, Chicago; Raymond Annis, Vincent S. Digiulio, and John J. McLaughlin, Joliet; Ralph K. Brooks, Great Lakes; Alfred J. Dowe, Waukegan; Holden K. Farrar, Winnetka; Jerome A. Kharasch, Forest; Larry McGowan, Decatur; Edwin E. Nyman, La Grange; Robert L. Sullivan, Galesburg; and David R. Welsh, Rockford.

Student AMA Resolutions

Among the resolutions passed by the House of Delegates of the Student American Medical Association at its 1961 meeting were

1. Support of the Kerr-Mills act
2. Opposition to compulsory social security for physicians.
3. Opposition to the King-Anderson Bill and similar legislation.
4. Disapproval of federal scholarships for medical students until other sources are completely explored.
5. In favor of intern and resident salaries reflecting educational achievements, the services rendered, and responsibilities accepted.

Physicians on state board

Four physicians have been appointed by Governor Kerner to the Board of Vocational Education in the Division of Vocational Rehabilitation of the Department of Public Health. They are Drs. William Gellman and Rilma Buckman, Chicago; Guy Renzaglia, Carbondale; and Edward I. Elisberg, Highland Park.

Dr. Gellman, executive director of the Jewish Vocational Services and Employment Center, Chicago, was made chairman. Dr. Elisberg is attending physician at Cook County and Highland Park hospitals and an associate in medicine at Northwestern University Medical School.

Dr. Renzaglia has been director of the Rehabilitation Institute and associate professor of psychology and guidance at Southern Illinois University for six years. Dr. Buckman is senior associate executive secretary of the health division of the Welfare Council of Metropolitan Chicago.

Blue Shield payments for 1960

The medical profession in 1960 received $731,131,187 from the 74 nationwide Blue Shield Plans for care of members, the National Association of Blue Shield Plans reported in June.

The amount represented an all-time high for a one-year period, and also represented nearly

90 per cent of the total 1960 income of these medical-surgical plans; less than 10 per cent of the total 1960 income was devoted to administrative expenses.

In its report, the national association indicated that Blue Shield payments to the medical profession had increased from nearly $116,000,000 in 1950 to the 1960 figure of $731,131,187.

State society elections

The Illinois Psychiatric Society elected its 1961-62 officers at a recent meeting. They are Drs. Melvin Sabshin, president; Lester Rudy, president elect; Harold Visotsky, secretary-treasurer; and Joel S. Handler and John Adams, councilors. Dr. Jewett Goldsmith was elected the delegate to the American Psychiatric Association Assembly. All are from Chicago.

The following 1961-62 officers of the Illinois Surgical Society were recently elected: Drs. Charles B. Puestow, president; Richard H. Lawler, vice president, both of Chicago; Kenneth H. Schnepp, Springfield, president elect; Charles E. Baldree, Jr., Belleville, vice president elect; W. James Gillesby, Hines, secretary; and Louis P. River, Oak Park, treasurer.

The Illinois Association of Blood Banks elected Drs. John Maloney, Bloomington, president for 1961-62. Other officers, all of Chicago, are Frank Trobaugh, Jr., president elect; William Mavrelis, vice president; and Morris Goldenberg, secretary-treasurer. Members of the Executive Committee are Dr. Douglas Huestis, Miss Shirley Busch, and Dr. Max Appel.

Legislation to benefit mentally ill

The Public Welfare Advisory Committee has endorsed Governor Kerner's recommended legislative proposals for effective treatment of mental illness in Illinois.

The Proposals include the reorganization of the Department of Public Welfare into the Department of Mental Health and the creation of a commission to study all aspects of the care, treatment, and assistance services for children and their families.

The committee also allocated the disposition of the $150 million Public Welfare Building Bond Issue approved by voters last November; $90 million is scheduled for rehabilitation and construction of existing facilities, $50 million has been reserved for future programming, and $10 million will be used to build a mental institution at Centralia.

The Illinois physicians inducted are John N. Schuetz, Blue Island; Uwe E. Freese and Warren H. Staley, Chicago; Charles D. Collins, Chicago Heights; Larry McGowan, Decatur; Francis P. Weyrens, Galesburg; Alan B. Sampson, Oak Park; Jerome A. Kharasch, Park Forest; and John Standard, Springfield.

Medical research essay contest winners

Twenty five high school students received prizes for their essays, "The Value of Animal Experimentation," at the annual meeting of the Illinois Junior Academy of Science in Urbana in May. The purpose of the contest, cosponsored by the Illinois Society for Medical Research and the ISMS, is to stimulate interest among students in careers in research and to inform them of the humane nature, value, and the necessity for the use of animals in these sciences. Winners, chosen from 662 entries, were as follows:

1st Place: Julie Shamvan, Oak Park and River Forest High School, $200 U.S. Savings Bond

2nd Place: Anita Cudia, Resurrection High School, Chicago, $100 bond

U.S. Savings Bonds of $25 were awarded to Kenneth Kober, Lane Technical High School, Chicago; Paul Ingevaldson, Immaculate Conception High School, Elmhurst; Erick A. Johnson, Oak Park and River Forest High School; Laurel Kolski, Nazareth Academy, LaGrange; Mary Ann Milkowski, Notre Dame High School, Chicago; James Miller, J. S. Morton High School—West, Berwyn; Barbara Campbell, St. Edward Central Catholic High School, Elgin; and Spencer Malecha, Griffin High School, Springfield.

Fifteen other students received $5 cash awards.

Deaths

Truman Anderson, retired, Chicago, a graduate of the Hahnemann Medical College and Hospital in 1918, died April 12, aged 67. He had practiced for 40 years in Chicago's Roseland area

before retiring 8 years ago and during both World Wars was a commander in the Navy Medical Corps.

Frederick N. Bussey*, Chicago, a graduate of the Rush Medical College in 1925, died May 24, aged 60. He was on the staff of Ravenswood Hospital and a member of the American College of Surgeons.

Oscar A. Dahms, Chicago, a graduate of the Rush Medical College in 1900, died May 18, aged 82. For 25 years he served on the Chicago board of health and from 1908 to 1923 was president of the Davenport board of education.

Ulysses G. Dailey*, Chicago, a graduate of the Northwestern University Medical School in 1906, died April 22, aged 75. He was emeritus chief of the surgical staff of Provident Hospital and a fellow of the American College of Surgeons. After studying in London, Paris, Berlin, and Vienna he returned to Chicago to become a lecturer in anatomy at Northwestern University Medical School, remaining there many years. He had been an associate editor of the Journal of the International College of Surgeons and in 1952 was named to the board of trustees of the College. He was a former member of the Mayor's Commission on Human Relations and a former president of the National Medical Association, receiving its distinguished service medal in 1949. Dr. Dailey was honorary consul of the Republic of Haiti and traveled internationally for both the International College and the state department giving lectures and conducting clinics. He had also worked extensively in founding and developing teaching clinics in the south.

Charles G. Davies*, retired, Blue Island, a graduate of the Rush Medical College in 1902, died April 15, aged 86. He had practiced in Blue Island from 1904 until he retired in 1958.

John A. Firtik, Chicago, a graduate of the University of Illinois College of Medicine in 1913, died October 4, aged 72. He was a veteran of World War I.

George G. Fouser*, retired, Phoenix, a graduate of the Northwestern University Medical School in 1904, died April 24, aged 91. He was a retired fellow of the American College of Surgeons and an emeritus member of the Illinois State Medical Society.

Robert C. Fringer*, Rockford, a graduate of the University of Wisconsin Medical School in 1935, died May 23, aged 49. From 1954 to 1956 he was medical chief of staff at Rockford Memorial Hospital and was a fellow of the American Academy of Ophthalmology and Otolaryngology. He did postgraduate work at the University of Pennsylvania and was a flight surgeon in the Army Air Corps in Africa and Italy during World War II.

Fred L. Glenn*, Chicago, a graduate of the University of Illinois College of Medicine in 1896, died April 20, aged 89. A former president of the Chicago Medical Association, he had practiced in Chicago's Austin area over 65 years. He had been on the staff of West Suburban Hospital since its founding and served on the Chicago Medical Society's membership committee for many years. He was a past president of the Austin Kiwanis Club.

Earl L. Gooden, Chicago, a graduate of the Howard University College of Medicine, Washington, D.C., in 1921, died May 26, aged 66.

Sydney S. Greenspahn*, Chicago, a graduate of the Northwestern University Medical School in 1920, died May 4, aged 68. He had for many years been medical director of the Inter-Insurance Exchange of the Chicago Motor Club and was a medical consultant for other insurance firms and several railroads.

Hubert F. Harman, Chicago, a graduate of the University of Illinois College of Medicine in 1926, died May 26, aged 65. He had been on the staff of the Illinois Central Hospital 30 years and had practiced in Chicago's South Side over 30 years. He was a World War I infantry veteran.

Earle E. Henson*, retired, Princeville, a graduate of the Chicago College of Medicine and Surgery in 1912, died April 1, aged 73.

Thomas G. Hill*, Springfield, a graduate of the Chicago Medical School in 1933, died May 10, aged 69. He was a member of the American Association of General Practitioners and had practiced in Springfield since 1941.

Joseph F. Jaros*, retired, Tampa, Florida, a graduate of the Northwestern University Medical School in 1912, died February 25. aged 76. He was an emeritus member of the Illinois State Medical Society.

Eugene P. King, Waukegan, a graduate of the Rush Medical College in 1925, died February 12, aged 68. A veteran of World War I, he was associated with St. Therese Hospital in Waukegan.

Roy W. Kline*, Chicago, a graduate of the Bennett Medical College in 1913, died May 21, aged 70. He was a Chicago physician for almost 50 years.

Elizabeth R. Miner*, Macomb, a graduate of the Denver College of Medicine in Colorado, died March 3, aged 93.

Clara M. Schunk, Blandinsville, a graduate of the University of Illinois College of Medicine in 1910, died January 7, aged 82. She was formerly connected with the Mountain State Memorial Hospital in Charleston, West Virginia.

LeRoy H. Sloan*, retired, Duneland Beach, Ind., a graduate of the Rush Medical College in 1917, died June 2, aged 68. He had been director of medical services at Illinois Central Hospital for 36 years before retiring two years ago and moving from Chicago to Duneland Beach. He was a member of the Impartial Medical Testimony Committee of the Illinois State Medical Society for the past two years and active on its Industrial Health Committee. He did postgraduate study in Vienna from 1927 to 1935 and was also at the National Hospital, London, Eng., during that time. In 1915 he was a fellow in pharmacology at Northwestern University and in 1937 was certified in medicine.

He was president of the American College of Physicians in 1953-54 and was named a master in 1959. In 1956 he was chairman of the Joint Commission for Accreditation of Hospitals. He had been an attending physician and then consulting physician at Cook County Hospital for many years and was a former clinical professor of medicine at the University of Illinois and a former associate professor of medicine at Rush Medical College. In addition, he had been a consulting physician at Copley Hospital, Aurora, a consultant in internal medicine at the VA Hospital in Hines, an associate attending neurologist at St. Luke's Hospital, now Presbyterian-St. Luke's, and a member of the American Hospital Association.

Richard Trumpauskas, Alton, a graduate of the University of Moscow Faculty of Medicine, Russia, in 1918, died January 3, aged 69. He was associated with the Alton State Hospital.

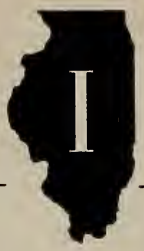
Alma T. Wead, retired, Wyoming, a graduate of the College of Physicians and Surgeons, Keokuk, Iowa, in 1895, died May 15, aged 90. Before retiring in 1957 she had practiced in West Jersey and Wyoming for 62 years. She was cited on her 50th anniversary as a physician by the Illinois State Medical Society and the American Medical Association. In Wyoming she was an over 50-year member of its chapter of the Order of the Eastern Star, of which she was a past worthy matron.

**Indicates member of Illinois State Medical Society.*

Diabetes insipidus

Four patients with polyuria and polydipsia were studied in order to make a differential diagnosis between diabetes insipidus and primary functional polydipsia. Several of the tests recommended for such cases were performed and the results were analyzed critically. It was concluded that the most definitive test consists of administering vasopressin intravenously immediately after a period of dehydration. If the Pitressin produces a more concentrated urine than the dehydration, diabetes insipidus is diagnosed; if not, compulsive polydipsia is diagnosed. It is felt that diabetes insipidus and psychogenic polydipsia are related in many ways, but that they differ in prognosis; hence it is important to differentiate between them. *F. Dies, M.D., S. Rangel, M.D., and A. Rivera, M.D. Differential Diagnosis Between Diabetes Insipitus and Compulsive Polydipsia. Ann. Int. Med. April 1961.*

BOOK REVIEWS



EDEMA: MECHANISMS AND MANAGEMENT. A Hahnemann Symposium on Salt and Water Retention. Edited by John H. Moyer, M.D., and Morton Fuchs, M.D., $15. Pp. 833. Philadelphia, W. B. Saunders Company, 1960.

Since edema is the cardinal manifestation of salt and water retention in the body, it follows that this massive volume is dedicated to a consideration of disturbances of fluid and electrolytes, and that the point of view is principally clinical. Listed as contributors are some one hundred and twenty-three names of well known investigators and "sophisticated clinicians," to borrow the phrase employed by one of the more sophisticated contributors. The material dealt with has been organized under eight headings. The first two comprise, respectively, a review and discussion of what is known and what may be conjectured about the physiology of fluid and electrolyte balance, and what is known and what has been tried in the pharmacology and therapeutic use of diuretics. The remainder of the volume contains sections on iatrogenic edema, hypertension, toxemia of pregnancy and premenstrual tension, edema of renal origin, edema associated with liver disease, and finally, edema of congestive heart failure. The papers are interspersed, from time to time, with panel discussions, often spirited, usually valuable from the point of view of the reader.

The symposium as a basis for a permanent compilation has certain advantages. It permits the inclusion of multiple viewpoints, and it keeps the intellectual air fresh and bracing, since there is nothing to prevent one participant from disagreeing with another or even having conflicting viewpoints. The participation of many speakers is apt to result in the rather careful definition of the scope of the paper and the treatment of each aspect of the subject by a speaker who not only is competent in that aspect but who is presumably riding his preferred hobby.

On the other hand, the symposium lends itself to a good deal of reiteration, particularly of introductory material, a fair amount of clearing of the throat as each speaker seeks to present himself and his subject. For the seeker after truth, also, versions may vary sharply enough to be definitely confusing—and this in a field in which lack of knowledge provides inevitably a generous increment of confusion. In this connection, the first section is by far the most murky, a fact which is very genially explained by Dr. Earl S. Barker in his introductory paragraph. Dr. Barker speaks of "the dauntless ingenuity with which the physiologists of each period have supplied plausible explanations for new observations although frequently forced to abandon cherished beliefs of preceding periods." Of such developmental anomalies, the concept of the fluid compartment, that of the cell membrane and even the patriarchal concept of Starling himself, have served to keep the symposial ball rolling briskly, if not always straight.

The section on physiology suffers also from the desire on the part of many of the contributors to redefine where redefinition provides rather an exercise than an illumination. In this section, also, the prolix is more prominent than elsewhere.

The section on pharmacology opens with an excellent survey of the field of diuretics by Dr. James M. Sprague of Merck Sharp and Dohme Research Laboratories, after which the various groups of these agents are separately considered in terms of their chemistry, their mechanism of action, and their applicability. The material contained in this section is likely to remain fundamental if not completely current until such time as the derangement responsible for the

formation of the edema is made available for correction, rather than only the resulting edematous state.

The succeeding clinical sections are distinguished by the experience and opinions of clinicians representing groups in various parts of the country. Thus, the body of teaching which is apt to develop into a local dogma is subject in this volume to the modification at least of neighboring dogmata.

The proceedings of the Hahnemann symposium furnish in one book a readable, even though fairly encyclopedic, compendium of knowledge pertaining to edema. It seems unlikely, even in the present climate of scientific progress, that it will attain obsolescence within the next several years.

Edith B. Farnsworth, M.D.

Cellular Aspects of Immunity. CIBA Foundation Symposium. Edited by G. E. W. Wolstenholme, M. B., and C. M. O'Connor. $10.50. Pp. 495. Boston, Little, Brown and Company, 1960.

A symposium by 32 participants on the role of the cell in immunology. This is a highly technical volume of major interest to those laboratory workers deeply involved in the problem of the mechanism of antibody formation and the nature of immunologic tolerance, and also those concerned with the effects of antigen antibody complexes on cells. This is not a book which ordinarily would be suitable for the practicing physician.

Guy P. Youmans, M.D.

Sight, A Handbook for Layman. Roy D. Scholz, M.D. $3.50. Pp. 166. New York, Doubleday and Company, 1960.

In most of the world a knowledge of medical ills and their treatment is strictly the province of specially trained people: physicians, herb doctors, witch doctors, and the like. Rarely, a man may study medicine as part of his interest in the humanities, but in large part the layman feels that the malfunctioning of his body is an area beyond his ken.

Because of the spread of general education, this is not true in the United States. Anyone who can read finds dozens of articles in the lay press on medical practice, medical research, and medical economics. Unfortunately, many of these articles are fragmentary and present only the more dramatic or even sensational aspects of disease. It is for this reason that a book such as Dr. Scholz's is most welcome. It is comprehensive enough to cover all the illnesses of the eye and does so without being alarming to the people most likely to read it, i.e., those with eye ailments.

In orderly fashion the author covers the anatomy of the eye, the eye examination, physiologic variations in ocular function, and diseases of the eye. Particularly helpful are the chapters devoted to the visually handicapped and to the eyes of those in school and industry. The line drawings are simple and clear, and the tone quiet and free from "journalese."

This book is recommended not only to the intelligent layman but to the physician as well. He may not only add to his store of knowledge about the eye, but, most important, it should improve his ability to communicate with the patient about his eye problems.

David Shoch, M.D.

Progress in the Treatment of Fractures and Dislocations — 1950-1960. Thomas B. Quigley, M.D., and Henry Banks, M.D. $2.50. Pp. 102. Philadelphia & London, W. B. Saunders Company, 1960.

This little book reviews progress in the treatment of fractures and dislocations over the past ten years. It treats fractures as well as some of the general principles of fracture management, including non-union, bonegrafting, open fractures. This book will serve as a ready reference by bringing current thought on fracture management to the medical profession. Of particular value is the bibliography consisting of 426 references at the end of the volume.

The book is espeically valuable to those concerned with trauma.

William A. Larmon, M.D.

Surgical Errors and Safeguards. Max Thorek, M.D. 5th ed. $25. Pp. 652. Philadelphia, J. B. Lippincott Co., 1960.

The fifth edition of this book has been rewritten from previous editions with the help of 22 collaborators. According to the senior author, the purpose of this volume is to point out the errors and the safeguards which should be remembered and considered in the practice of

surgery, for no person is so perfect in his knowledge or experience that an error in opinion or action is not possible.

This volume is organized so that systems, organs, tissues, etc. are considered individually. This could be improved by a clearer delineation and grouping of material. Some of the chapters are excellent; however, much of the volume is rather rambling, extended, and confusing. Treatment for specific problems is indicated, but in some instances this is outmoded as in the injection treatment of hernia. There are glaring omissions such as in the lack of discussion of electrolytes, both pre- and postoperative. Many of the illustrations are excellent, but others are of such poor quality that the point alluded to is almost completely missed.

In this day of adequate, excellent graduate programs for the young physician who wishes to do specialty work, this book has little purpose and will not be as helpful to the student or practicing physician as a careful and precise volume of operative and postoperative care. It is a volume outmoded for the serious student and could never be adequate for the physician who wishes to "dabble" in surgery.

W. Harrison Mehn, M.D.

Blood Diseases of Infancy and Childhood. Carl H. Smith, M.D. $17. Pp. 572. St. Louis, Mo., The C. V. Mosby Company, 1960.

In the preface the author states that the purpose of the book is to present the essentials of pediatric hematology in concise form for the medical student and practitioner. The various blood conditions are presented against the background of normal development of infancy and childhood. Subject matter is covered clearly and adequately. References are found at the end of each chapter. Emphasis is placed on the diagnosis and management of the blood diseases encountered in pediatric practice.

Of special interest to the pediatrician is the section dealing with erythroblastosis fetalis (hemolytic anemia of the newborn infant). Steps are outlined for the treatment of hyperbilirubinemia. The author stresses the importance of incompatibility within the ABO blood group system as a common cause of erythroblastosis. In erythroblastosis due to ABO incompatibility jaundice is frequently mild and is overlooked in the first day of life. The physician is often confronted with unexpected hyperbilirubinemia on the third or fourth day of life. To avoid this contingency, the ABO blood group and Rh typing of the mother and infant should be conspicuously placed on the chart and susceptible infants kept under scrutiny.

The author includes recent contributions in the field of immunohematology, genetic analysis, electrophoretic examination, and inborn errors of metabolism. This book is a valuable addition to physicians interested in pediatric hematology.

Eugene L. Slotkowski, M.D.

Management of Hypertensive Diseases. Joseph C. Edwards, M.D. $15. Pp. 439. St. Louis, The C. V. Mosby Company, 1960.

The last decade has brought forth many effective new drugs capable of reducing the blood pressure and apparently of increasing the life span of patients with hypertension. Pharmacologic advances have made good therapy obsolete even before practicing physicians have learned its use. New books, at least fifteen within the decade, have appeared when their authors thought there was a plateau in the rapid ascent of knowledge of sufficient duration to justify definitive instruction for practical therapy; but at least until now, the book was virtually antiquated by the time the publisher could release it.

Dr. Edwards shows: "The choice of drugs is empirical trial and error coupled with sound judgment and experience gained from discerning clinical observation . . . The kind, sympathetic approach of the physician helps immensely in the process of management of the hypertensive patient, who is an individual and should be treated as such." He has succeeded admirably well in supplying up-to-date information, referring to literature within a few months of the publication date, October 31, 1960. Over 1,600 selected references to other recent publications are included.

The book is written "for the busy physician in practice who wants the latest information on the treatment of hypertension and guidance in selecting proper medication for a particular patient." It searches deeply enough into the subject to be suitable for senior residents and practicing specialists in internal medicine. It is difficult reading, unsuitable for hasty scanning. A great abundance of statistical data interrupts the text. The few errors in text, resulting in all

likelihood from the desire to provide current instruction during a maelstrom of progress, are fairly easy for the discriminating reader to identify and are not likely to endanger patients. Inevitably, only a short time is likely to elapse before revision will be necessary.

William H. Wehrmacher, M.D.

Cardiovascular Dynamics. Robert F. Rushmer, M.D. $12.50. Pp. 503. Philadelphia, W. B. Saunders Company, 1961.

This book is an extensive revision and enlargement of a well known text, previously published under the title *Cardiac Diagnosis*. It is intended mainly for medical students, but internists and cardiologists will derive great pleasure and obtain considerable information by reading it.

The components of the cardiovascular system are presented in terms of their structure, function, and control, both under normal conditions and in various diseases. Chapter 1 is partly devoted to the study of flow through various segments of the circulatory system, a topic which the author has personally studied. The description of the function of capillaries, lymphatics, and veins deserves special praise because it is often too briefly described in similar works.

The sequence of events during the cardiac cycle is illustrated by cinefluorography and angiocardiography, as well as by volume and pressure curves. The initial systolic expansion of the free left ventricular wall is one of the facts brought to light by the newer methods of study.

The relation of myocardial fiber length to ventricular volume, the effect of epinephrine on the myocardium, the study of the heart by means of ultrasounds, and the analysis of ventricular performance with electronic computers, are some of the topics covered in Chapter 3. Chapter 4 deals with peripheral vascular control, Chapter 5 with pressure measurements. The description of electric pressure transducers will be of great use to many researchers. The succeeding chapters take up cardiovascular response during exertion, a topic particularly studied by the author: the coronary system; and the electric activity of the heart. Cardiovascular sounds are discussed in Chapter 11. The theory that the rapid vibrations of the heart sounds are caused by accelerations and decelerations of the blood is of great interest and will undoubtedly be the source of lively discussions. Rheumatic and congenital heart diseases, the study of cardiac reserve, and that of blood volume and congestive failure complete this magnificent book.

The beautiful and simple schemes presented to the readers are of great help in abbreviating the text without decreasing the clarity of explanations.

A. A. Luisada, M.D.

Haemopoiesis: Cell Production and its Regulation. G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P. and Maeve O'Connor, B.A. $11. Pp. 490. Boston, Little, Brown & Company, 1960.

This book contains the proceedings of a symposium on Haemopoiesis sponsored by the Ciba Foundation and held in England from Feb. 2-4, 1960. Twenty-seven authorities from Europe and the United States participated in or attended the symposium with Prof. J. M. Yoffey acting as chairman. Sixteen papers were presented. The first part of the symposium deals with formation and development of leukocytes with special emphasis on the lymphocyte and lymphomyeloid system. The use of radioisotopes, tritiated thymidine and tissue cultures in the study of blood cell formation is discussed in detail.

The last part of the symposium is devoted to factors regulating red cell formation with special reference to the erythropoietic-stimulating factor, or erythropoietin. Included in the subject matter are vitamin B_{12} response to blood loss, kinetics of erythropoiesis, humoral and other factors controlling hemopoiesis, human urinary erythropoietin and induced polycythemia as a model for studying erythropoietic factors.

As is to be expected, much of the material presented has been published elsewhere.

Very useful features of the symposium to workers in this field are the informal discussions following each presentation, the pertinent bibliographies with an alphabetical index of all authors cited and the complete subject index. This book should be a valuable addition to the hematologist's library.

Howard L. Alt, M.D.

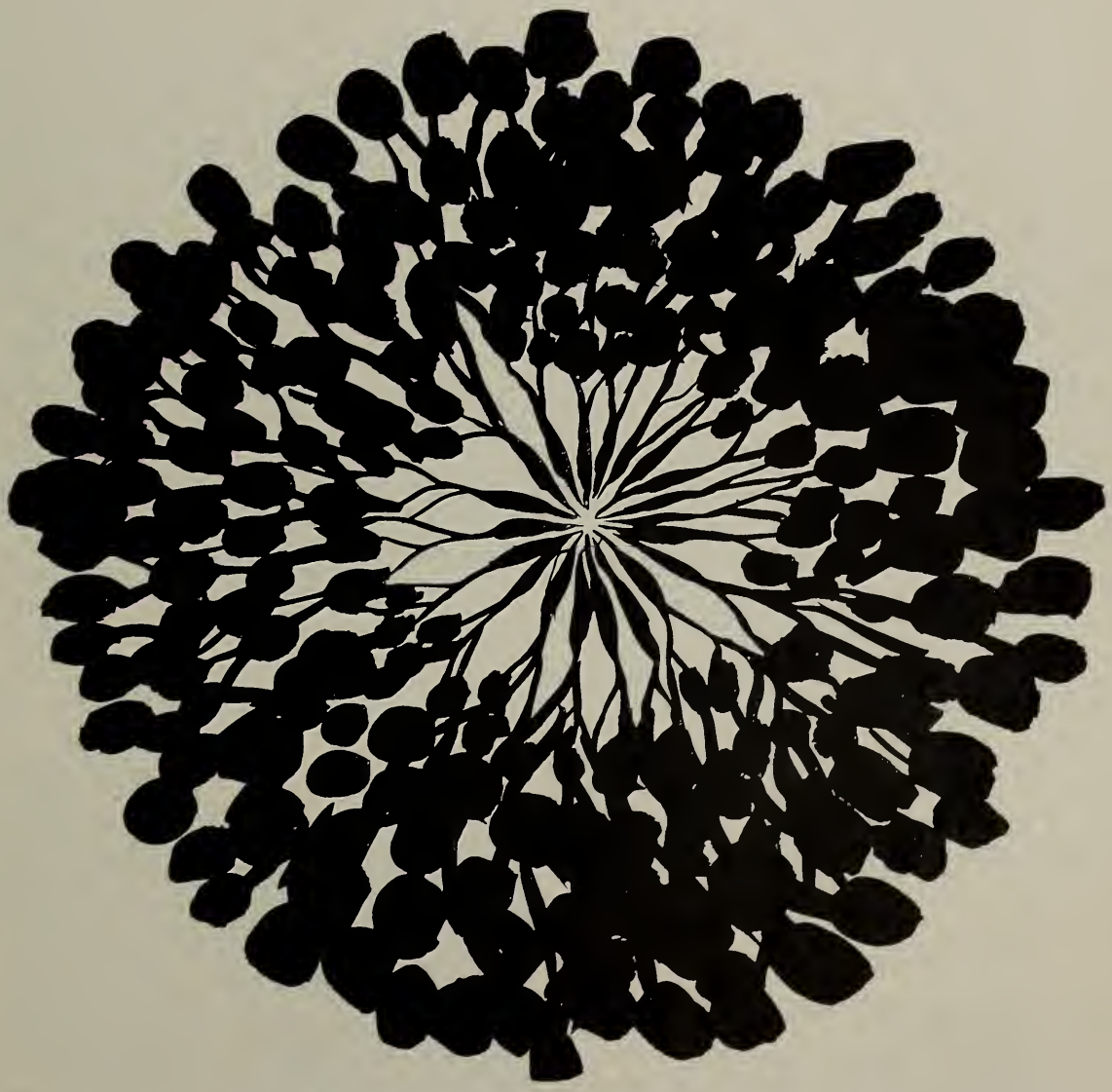
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Exercise and cholesterol

Aside from the marked increase in the consumption of saturated animal fats, there is probably no more profound alteration in recent times in this country than in the nature of our occupational physical activity. Mechanization, automation, and transport have turned most jobs into sedentary push-button ones. Field studies have revealed that the average daily physical energy expenditure of the modern farmer removes him from the category of a heavy worker. A large factory in Cleveland, Ohio, has found it necessary to institute a program of recess periods each afternoon so that the employees may engage in some sort of physical activity in order to maintain physical fitness. Some epidemiological studies have had difficulty in gathering sufficient numbers of people engaged in heavy labor to make the studies statistically significant. How much this has to do with the increase in coronary atherosclerotic heart disease is still problematical. *David M. Spain, M.D. Problems in the Study of Coronary Atherosclerosis in Population Groups. Ann. New York Acad. Sc. Dec. 8, 1960.*

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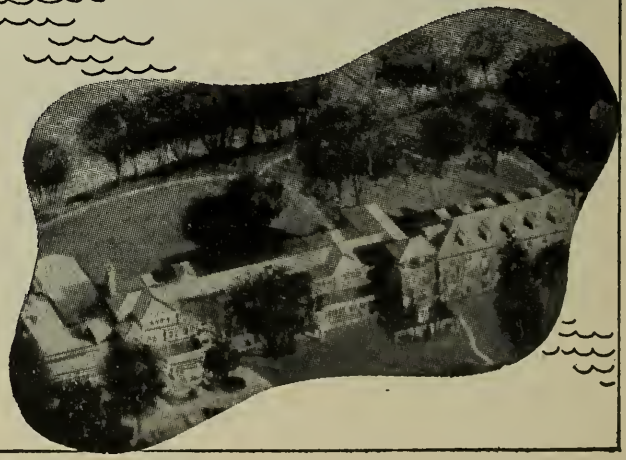
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Blue Shield's efforts

Efforts to make physicians generally aware of the crucial nature of Blue Shield's situation have met with only moderate success. Meetings devoted to the consideration of the problems of individual Blue Shield Plans have held little interest for the average physician. Witness the pathetically small attendance at their annual business meetings where policies important to every physician are determined. There is even less concern shown for the national Blue Shield program. This situation, too, is taking on serious proportions because if participating plans are not standardized failure would seem inevitable.

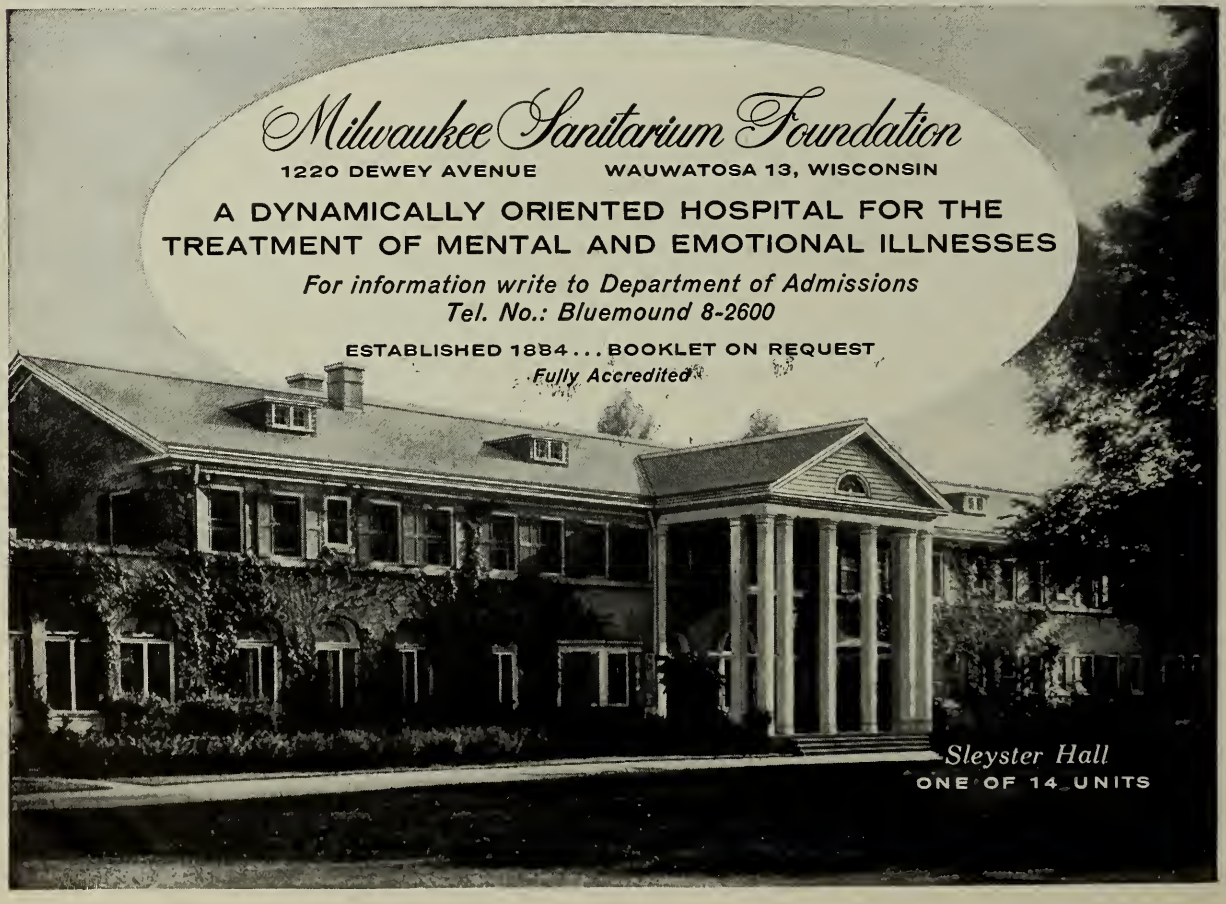
It is doubtful if many articles appearing in medical journals about voluntary health insurance are widely read by doctors. At least this is the impression one gains in listening to small groups of physicians when they discuss the subject.

Again, time is of the essence where voluntary health insurance is concerned. Medical leaders know it. They are trying desperately with more or less effectiveness to meet the demands of the people through voluntary methods, but they need the support of greater numbers of the profession.

What are the objectives of forward-looking Blue Shield leaders and their supporters? Briefly, they are the establishment of standards to which all of the plans will adhere, general adherence to the service principle; broadening of benefits to meet the demands of the people; a much closer liaison between National Association of Blue Shield Plans and the American Medical Association; and, finally, a cohesive national organization having a far more significant influence in dealing with this country's prepaid medical care problems than in the past. *In & Out of Focus By the Observer. Med. Ann. District of Columbia. December 1960.*

Thyroid therapy during pregnancy

Numerous miscarriages have been observed in patients in whom the BEI or PBI levels either fail to rise during pregnancy or remain at a suboptimal level. Thyroid therapy improves the salvage of pregnancy in many of these cases. *Ralph C. Benson, M.D. Treatment of Thyrotoxicosis During Pregnancy. GP. December 1960.*





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Kestler reports in J.A.M.A. (April 30, 1960) that conventionally treated low-back syndrome patients required an average of 41 days for full recovery (range: 3 to 90 days). The addition of Soma therapy in this comparative investigation reduced the average to 11.5 days (range: 2 to 21 days). With Soma, patients averaged full recovery 30 days sooner.

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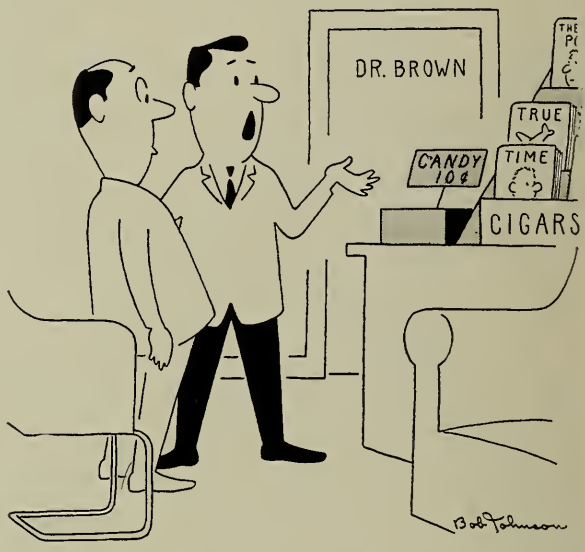
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Personal injury suits

Since many patients with head injuries become involved in litigation, usually personal injury suits, and since verdicts in such civil suits are largely determined by medical testimony, the physician becomes secondarily involved on the side of both the plaintiff and the defendant. The differentiation of organic and psychic symptoms, although somewhat artificial, may be helpful to both lawyers and doctors in considering disability, prognosis, and rehabilitation. The plaintiff's attorney may find relevance in the fact of two diagnoses, two types of disability. It may be of interest to the defendant's attorney that not all symptoms following head injury are necessarily organic and permanently disabling, but that some are functional reversible. Assuredly, the patient, the patient's family, and the doctor should be deeply interested in learning which symptoms are amenable to sound psychological handling and rehabilitation, and which may be irreversible. *Herbert C. Modlin, M.D. Psychological Reactions to Head Injuries. Nebraska M. J. May 1961.*



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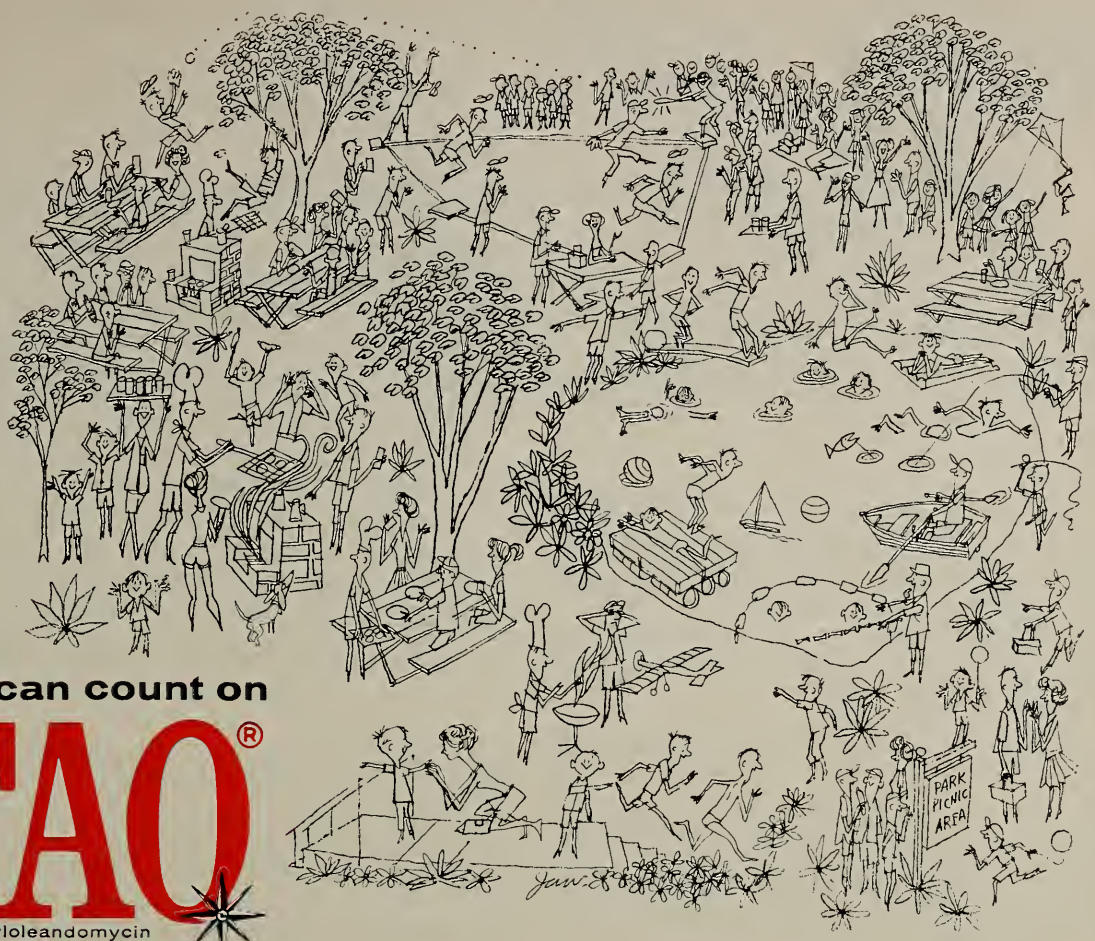
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References: 1. LeFebvre, M., et al.: Antibiotics Annual 1959-1960, New York, Antibiotica, Inc., 1960, p. 755. 2. Fisher, A. A.: Med. Times **88**:1056 (Sept.) 1960. 3. Steller, R. E.: Antibiotic Med. & Clin. Therapy 7:691 (Nov.) 1960. Literature on request.

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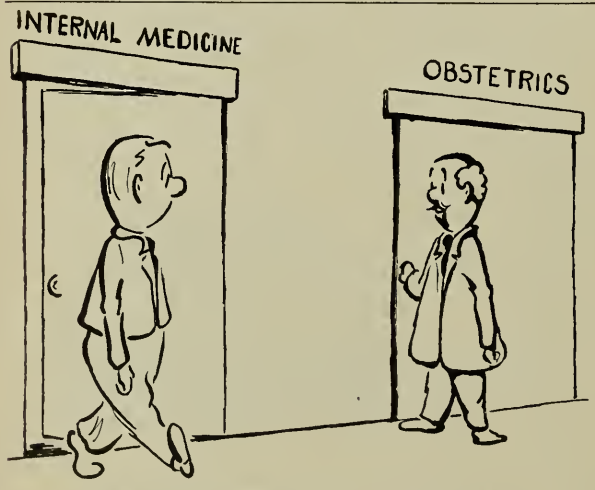
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Advance in rabies control

The recent development of the Flury strain of chick-embryo-adapted live-rabies virus by Koprowski is another significant advance in rabies control. Although this vaccine has been extensively and effectively used for canine inoculation, it is not known whether it is safe and effective enough for routine human use. Studies by Schwab in 1954 in human subjects indicated that little or no virus multiplication occurred in man. Present evidence seems to be sufficient to warrant the use of Flury virus vaccine for human use as a prophylactic agent for those subject to high risk of exposure to rabies. Its use for postexposure protection is indicated only in those who have had previous administration of brain-tissue vaccine or in those who develop signs of sensitization. *A. William Menzin, M.D. Current Immunization Methods and Materials. Arch. Int. Med. March 1961.*

Space ships or nothing

Particularly in the drug field, we have noted that the Soviets have failed to develop even one new product. This is undoubtedly true of the other items in this classification. By adapting from others they are relieved of the creative and technical effort plus the experimentation. Their claim is that a tremendous amount of human energy is wasted in the United States where hundreds of our scientists are engaged in this inventive process. By choosing from the hundreds and thousands of the best of the product produced in other countries to copy and produce in the Soviet Union, they claim they release thousands of their young scientists for work in key revolutionary industries which they claim will ensure their domination of the world.

How like some of our own activities in pharmaceuticals here. The production of generic equivalents is a comparatively easy process; their use in certain of our pharmaceutical dispensaries, lends an aura of respectability to the producer. How unlike our respected American way of life! *Newell Stewart. What is the Generic Equivalent End Product? South Dakota J. Med. & Pharm. December 1960.*

For everything you have missed you have gained something else. — *Emerson*

Abstract of Council Actions

Meeting of July 16, 1961

EDUCATIONAL FOUNDATION BEING ORGANIZED

Mr. John W. Neal, special counsel, was requested to draw up papers of incorporation for an educational foundation for the Illinois State Medical Society. The board of directors will be composed of the president, secretary and chairman of the Council of ISMS. This is being established principally to make it possible for the Society to accept bequests and grants for education and research endeavors which ordinarily cannot be accepted under the present corporate structure of ISMS.

TO SURVEY DOWNSTATE CARDIOVASCULAR PROBLEMS

The ISMS will co-operate with the Illinois Department of Public Health in a study of a program to survey cardiovascular problems downstate, similar to that done recently in Cook County. The survey will be confined to young people if the committee recommends favorably upon the proposal. Dr. John Lester Reichert, Chicago, was named chairman of the committee to co-operate with the department.

WORKERS ON VIRAL HEPATITIS VACCINE ARE CITED

A resolution commended Dr. Joseph D. Boggs and his associates for their work in developing a promising vaccine to prevent viral hepatitis. The clinical work was carried out at the Illinois State Penitentiary, Joliet, where more than 200 prisoners volunteered as test subjects. Also cited were Parke, Davis & Co., and its research workers who co-operated in the research.

COMMITTEE TO AID IPAC IN MEDICAL CARE OF AGED

A committee consisting of Drs. Edwin S. Hamilton, president; George F. Lull, president-elect; H. Close Hesseltine, immediate past president, and Burtis E. Montgomery, councilor, was named to co-operate with the IPAC in developing rules and regulations for the medical care of the needy aged over 65, provided for in S.B. 197, passed by the last Legislature.

ILLINOIS PHYSICIANS GET IMPORTANT AMA POSTS

Dr. Edwin S. Hamilton, president, reported that Dr. Burtis E. Montgomery of Harrisburg had been elected as a member of the AMA Council on Medical Service and that Dr. Percy E. Hopkins of Chicago had been elected as vice chairman of the AMA Board of Trustees.

Dr. Arthur Goodyear, chairman of the Illinois Delegation cited the delegates for their excellent cooperation during the AMA sessions. Staff members were also commended for their excellent services.

Editor's Note: A full report on the ISMS resolutions introduced at AMA was sent to all ISMS delegates and county society secretaries. This report failed to include the names of two delegates who attended, namely: Dr. Carl F. Steinhoff and Dr. H. Kenneth Scatliff, both of Chicago.

COUNTY SOCIETIES, AUXILIARY LAUDED FOR LEGISLATIVE AID

Mr. Robert L. Richards, executive administrator, reported that county medical societies and their woman's auxiliaries have been most helpful in the legislative program. He said that 19 county societies had made good use of the ISMS advertising material in the promotion of S.B. 197, designed to implement the Kerr-Mills law in Illinois. Thousands of requests for literature were fulfilled, requiring several hundred thousand pamphlets.

CAMPAIGN AGAINST KING-ANDERSON BILL LAUNCHED

Mr. Richards also reported that a "Pen a Line for Freedom" mail campaign to congressmen from Illinois was launched. Each member of the Society was urged to contact three friends, asking each to write his congressman urging a vote against the bill. The staff directors also contacted 34 state organizations on the subject, most of which indicated a willingness to join on the side of medicine. The Illinois Chamber of Commerce planned to send a representative to testify before the House Ways and Means Committee.

Mr. Donald L. Martin, director of public relations, reported that the legislative--public relations program has been completely implemented as to the production of program aids. The "Speak Up Doctor" program, outlined in recent issues of "The Pulse" has brought plaudits from the AMA and other state medical societies. The PR Committee is now at work on public relations programs for county societies and expects to present them this Fall. Plans are also being developed to approach other state societies concerning joint efforts in the creation of PR aids with a view of reducing unit costs.

SUCCESSFUL LEGISLATIVE YEAR REPORTED

Mr. Walter L. Oblinger, director of legislative activities, reported that the ISMS had an outstandingly successful record in the last Legislature. He said all legislation offered, endorsed, or supported was enacted; that all legislation opposed failed to pass, and that certain bills were amended to comply with Society suggestions. The year brought forth positive programs and constructive and popular stands on various subjects before the Legislature.

INSURANCE FORMS MAILING WELL RECEIVED

Mr. Roger N. White, director of medical services and economic research, reported widespread, favorable reaction to the mailing of the insurance forms to all members of the Society. Requests had been received from more than 700 physicians for additional blanks, along with complimentary letters. It was brought out that the forms could not be used for Workmen's Compensation or Blue Shield cases.

COUNCILOR DISTRICT MEETINGS PLANNED

Four downstate councilor districts (5th, 6th, 7th, 9th) expressed desires for the holding of councilor district meetings in the next year. Third district meetings also will be held in co-operation with the Chicago Medical Society.

COMMITTEE FUNCTIONS TO BE SPELLED OUT

The Executive Committee reported that it planned the appointment of a subcommittee to study committee structures (constitutional and councilor) and to write up definitions of the scope of committees.

EMERITUS AND RETIRED MEMBERS ELECTED

Council approved emeritus status for Drs. Ferdinand F. Hass, Peoria County; Herbert B. Henkel, Sangamon County; Henry J. McCoy, Lee County.

The following were elected retired members: Drs. Herman J. Andeelmann and John W. Muncy, Will-Grundy Counties; Norman L. Sheehe, Winnebago County; Ernest W. Spieler, Chicago Medical Society.

NEXT COUNCIL MEETING IN CONJUNCTION WITH COMMITTEE CHAIRMEN SEPTEMBER 16 and 17

The next meeting of the Council will be held at the Drake Hotel, Saturday, September 16. A meeting with all committee chairmen will be held on Sunday, September 17 for the purpose of discussing programs and activities for the year. Included will be discussion groups on implementation of actions taken at the May 1961 meeting of the ISMS House of Delegates.

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Published monthly by the Illinois State Medical Society, 360 N. Michigan Avenue, Chicago 1, Ill. Subscription $5.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, and Mexico. $6.00 per year for all foreign countries included in the postal union. Canada, $5.50. Single current copies 75 cents.

Second class postage paid at Mendota, Illinois. POSTMASTER: Send notices on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago 1, Ill.

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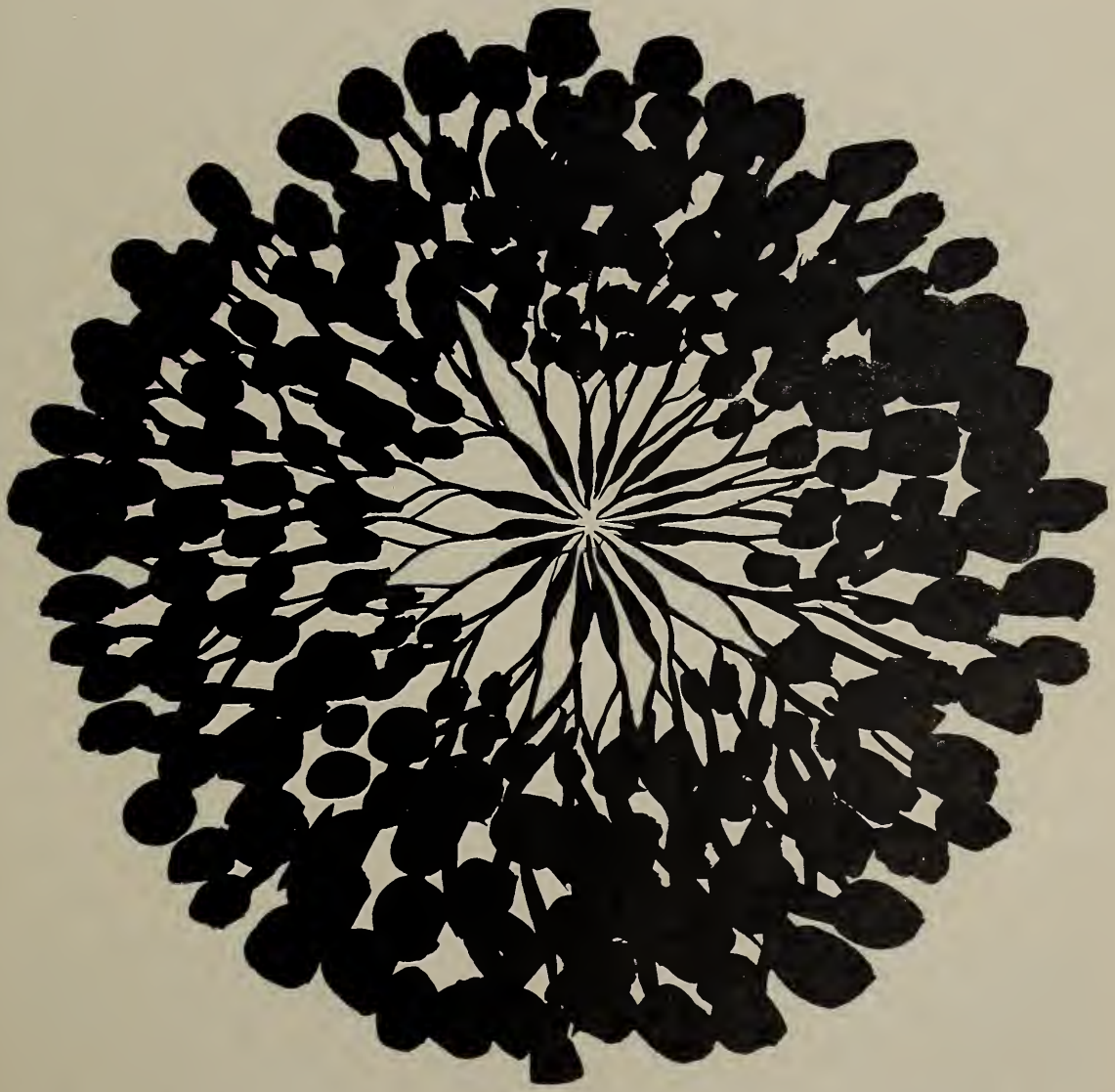
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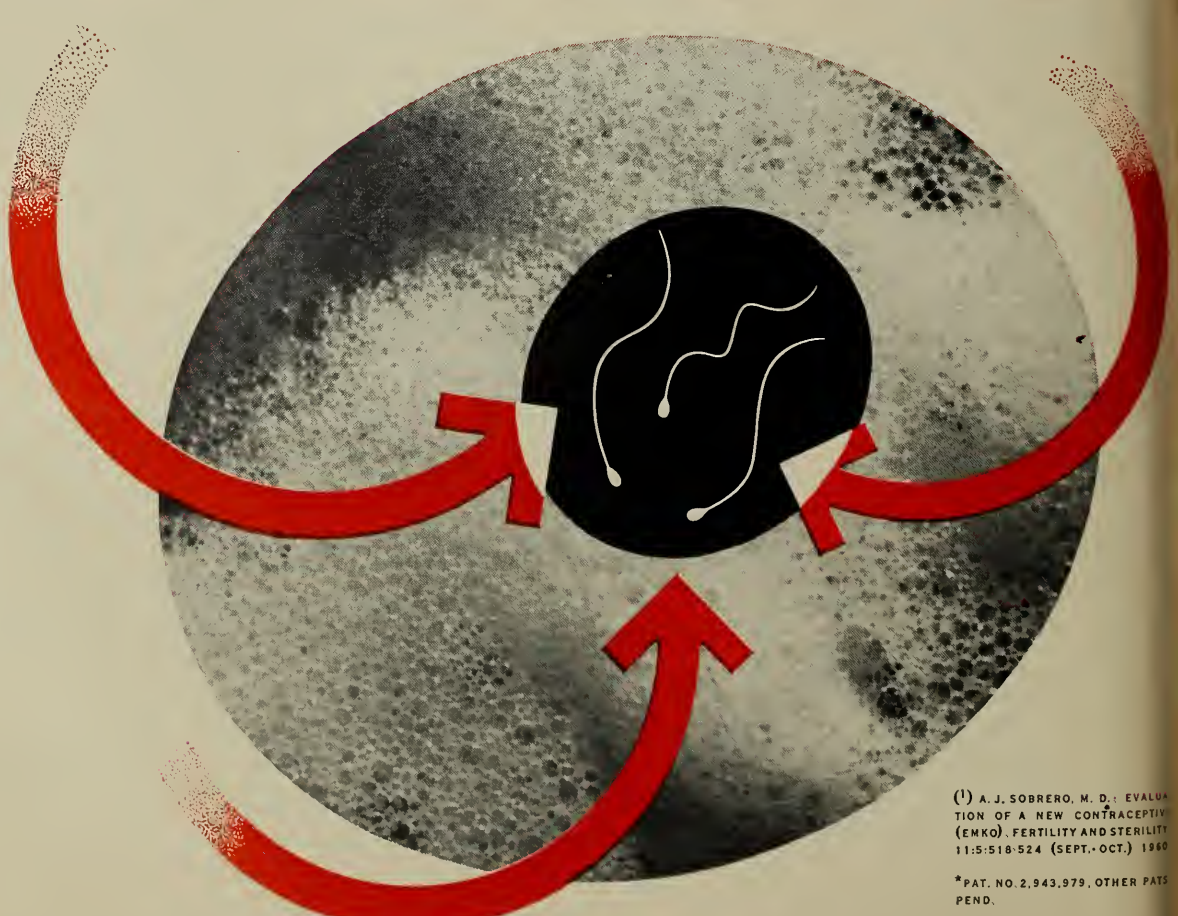
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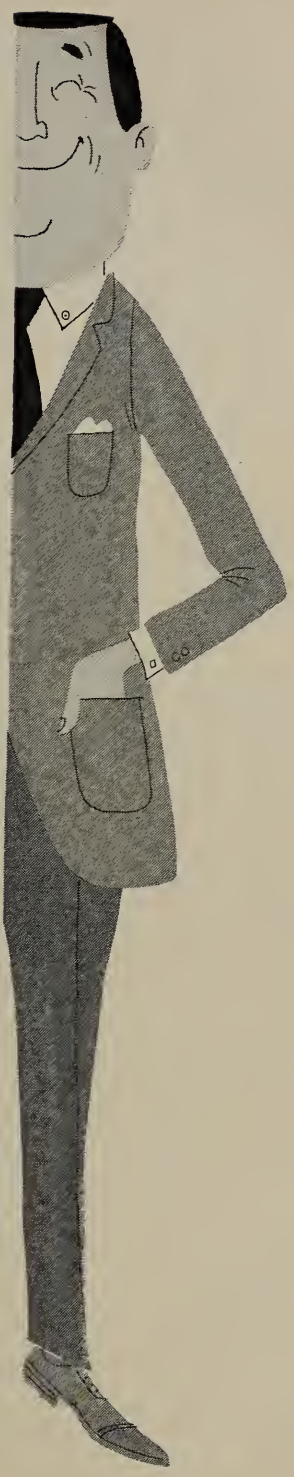
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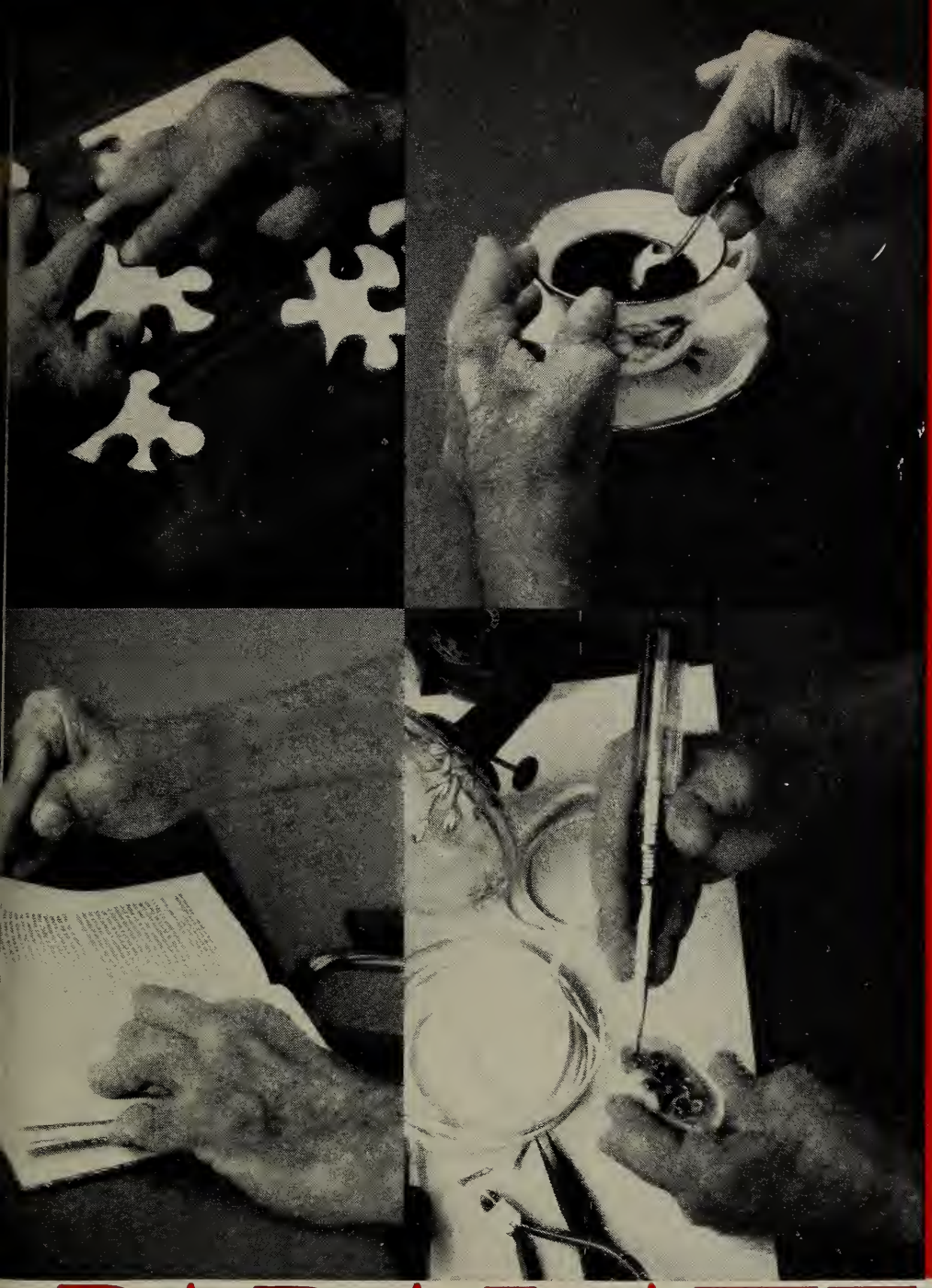
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The American Medical Association opposed three major provisions of a bill (S. 1552) that would greatly increase the powers of the federal government in regulation of the ethical drug industry.

These three provisions would turn over to the Department of Health, Education and Welfare and the Food and Drug Administration the responsibility for (1) relaying of drug information to physicians, (2) selecting the names of new drugs, and (3) deciding whether a drug is of value in treating human ills.

The AMA didn't take a position on the bill as a whole because certain of its provisions, "such as the Sherman Act and patent law amendments, are outside our area of competence."

Dr. Hugh H. Hussey, Jr., chairman of the AMA's Board of Trustees and Dean of Georgetown University (Washington, D.C.) School of Medicine, was the chief AMA witness at the opening of hearings on the legislation before the Senate Antitrust and Monopoly Subcommittee headed by Sen. Estes Kefauver (D., Tenn.). Dr. Hussey was accompanied by Dr. Ernest B. Howard, assistant executive vice president of AMA, and C. Joseph Stetler, AMA's general counsel.

With Congress trying for adjournment by about September 1, and much "must" legislation still to be acted upon, it appeared highly unlikely that Congress would complete action on the drug legislation this year.

Dr. Hussey reviewed for the subcommittee AMA's 70-year-record of taking the lead in endorsing legislation designed to insure the purity of drugs and food. The AMA carried on intensive legislative efforts in the field and "is generally credited with being one of the major forces that brought the first Pure Food and Drug Act into being" in 1906, Dr. Hussey said.

Dr. Hussey cited these AMA aims that "we, as physicians, are desirous of achieving:

"We want all physicians to be well-trained and fully informed on all aspects of the practice of medicine.

"We want this body of knowledge and reservoir of skills to include a high degree of competence in the selection and proper use of drugs.

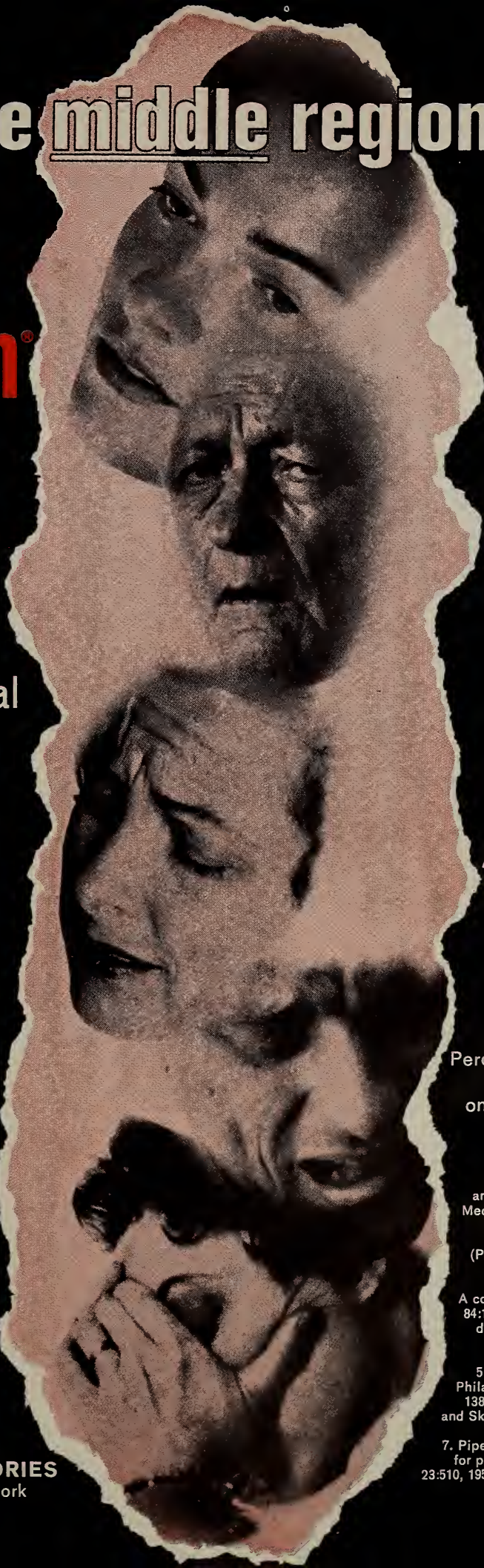
"We want a continuing and expanding flow of useful drug products placed at the disposal of these physicians."

Dr. Hussey pointed out that the AMA already conducts an intensive program of informing physicians about new drugs and that this program is now in progress of being greatly stepped up. "The medical profession believes that the education of physicians is the responsibility and perogative of the profession itself," he said.

Regarding determination of the efficacy of a new drug, Dr. Hussey said, "We believe that only the physician has the knowledge, ability, and responsibility to make a decision as to what drug is best for a particular patient. He should

(*Continued on page 24*)

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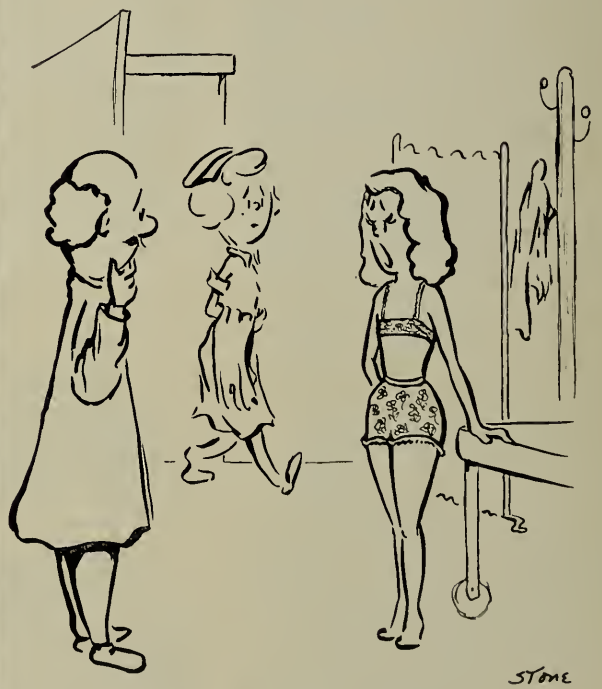
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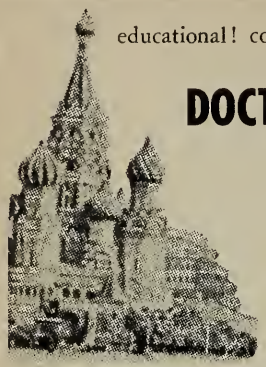
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Migratory urge

Study of internally migrating groups within the United States of America has shown that complex social and economic factors will determine the social class position and intellectual quality of those who migrate (Klineberg, 1958). Australia at present is receiving immigrants both from economically depressed and overcrowded countries around the Mediterranean Basin, and from Western European countries where the economy is booming, living standards are rising and the population is relatively stable. From time to time there are additional influxes of political refugees, whose migration is enforced. It is reasonable to assume that most voluntary migrants from depressed and overcrowded countries are attracted by Australia's open spaces and rapidly developing economy; but what about the others? What impels people to leave a familiar homeland in prosperous times, to settle in a relatively unknown country? Several motives are possible. They may object to increasing governmental supervision of their lives, as occurs in some crowded European countries, and seek



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greater freedom by moving to a frontier of western civilization; though if they do, many lack the courage of their convictions, since they remain in cities in Australia, rather than striking out for the "frontier". They may fear calamity in a future war, wish to escape from a potential battleground. They may be adventurers, restless for change and excitement, challenged by the unknown. They may be people for whom "the grass is greener on the other side of the fence". They may have been unable to find a satisfying place in the society of their homeland, either because of their own inadequacy, or because no opportunity exists there for full employment of their particular talent. They may seek a "promised land" where all their troubles will vanish as if by magic, in which case their adjustment to their new environment will be impaired when this expectation is unfulfilled (Hoff, 1958). It is axiomatic that people content with their lot in life do not migrate. When the invitation to migrate is seductively worded and the journey costs nothing, what kinds of people will be attracted? *J. M. Last. Culture, Society, and the Migrant. M. J. Australia. March 18, 1961.*

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The ILLINOIS Medical Journal

Official Journal of The Illinois State Medical Society

AUGUST, 1961
VOL. 120, No. 2

Peyronie's Disease

Donald Rolnick, M.D., *Chicago*

Peyronie's disease has long been a disturbing problem for urologists. Other terms used to describe the condition are plastic induration of the penis; plastic induration of the corpora cavernosa; fibrous and chronic cavernositis; primary indurative cavernositis; circumscribed fibrosis, fibrous placques, and fibrous sclerosis of the penis. Ephemerides first reported it in 1687[3] and La Peyronie defined it more fully in 1743.[7] Prior to World War I the condition was frequently called Van Buren's disease because of Van Buren and Keyes' report in the New York Medical Journal in 1874. Only in more recent years has Peyronie's name been held synonymous with the condition.

Peyronie did not describe the disease as we know it today[12] but noted it in his article "Some Obstacles Opposing the Natural Ejection of Semen." He described "rosary beads" along the dorsum of the penis which caused a dorsal angulation during erection. He did not recognize the basic pathology as a fibrous placque lying between Buck's fascia and the tunica albuginea of the corpora cavernosa.

The etiology is unknown.[2] Trauma, gout, diabetes, arthritis, vascular disturbances, venereal diseases, inflammatory fibrosis, hormonal disturbances, and heredity have all been suggested as possible etiologic factors.

Peyronie's disease is not a rare condition. The large majority of reported cases occur between the ages of 50 to 60, but cases have been reported in the 20 to 30 year age group and in the eighth decade of life. The condition is not incapacitating and does not shorten life. However, it may be extremely disturbing to the individual and may be a major problem for him.

The lesion is easily palpated beneath the skin. The corpus spongiosum and urethra are never involved. The placques are most commonly located on the dorsum of the penis in the midline near the corona, but may be located anywhere from the base of the penis to the glans and may be situated laterally and occasionally laterоventrally. They vary in length and thickness and exist as cords, nodules, or placques. They are sharply circumscribed, irregular and firm, hard, or bony in consistency. Microscopically the

From the departments of urology, Cook County Hospital, Michael Reese Hospital, and The Chicago Medical School, Chicago.

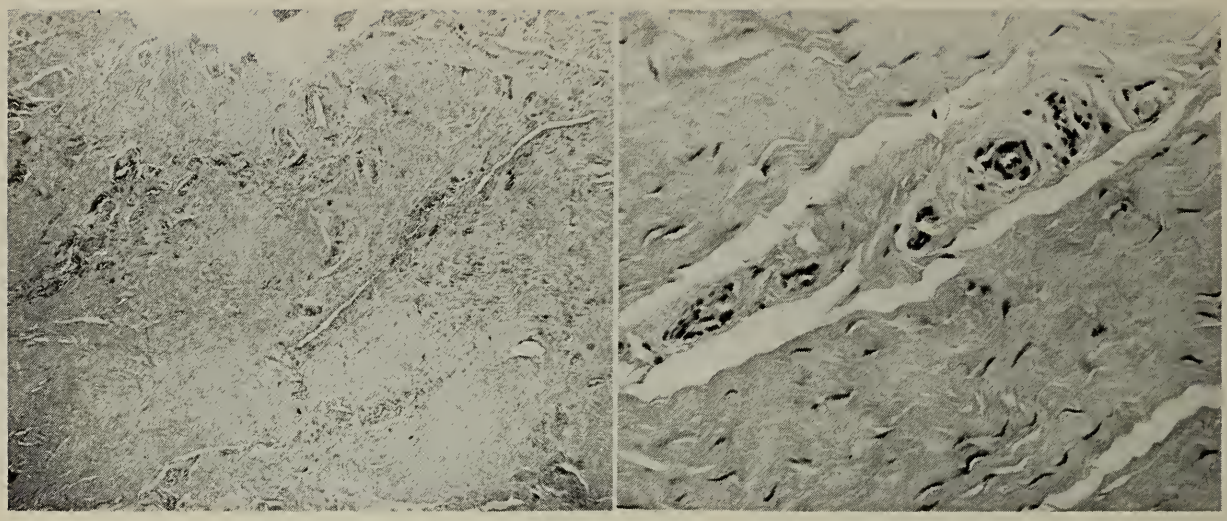


Figure 1. Low power microscopic section through a Peyronie's plaque showing the characteristic marked fibrosis. Figure 2 (right). High power microscopic section through a Peyronie's plaque showing bundles of collagen fibers with fibroblasts between them, a few blood vessels, and a few elastic fibrils.

plaques show bundles of collagen fibers with fibroblasts between them, a few blood vessels, and a few elastic fibrils, and the lesion resembles a keloid (Figs. 1 and 2). Bone and cartilage may develop in placques present for long periods of time. There have been no reports of malignant change nor ulceration.

The disease may be entirely asymptomatic, particularly in older patients, in whom the condition may be discovered incidentally on routine examination. The lesion produces symptoms only during erection, the most common symptom being dorsal angulation which may be painful and prevent intromission. Decreased libido and loss of potency commonly occur. Peyronie's disease does not cause urinary symptoms.

Treatment

Treatment is imperfect and difficult to evaluate. Spontaneous regression of the lesion with disappearance of symptoms may occur. The placque may develop to a certain size and then not become any larger. In addition, the patient may respond differently to the same therapy given at different times.

Alpha-tocopherol seems to be the treatment of choice. The use of tocopherols in the treatment of Peyronie's disease was first described by Scott and Scardino in 1948.[8] It was based on Steinberg's encouraging results with vitamin E[9,10] in the treatment of primary fibrositis and Dupuytren's contracture of the hand. Both of these conditions and Pyronie's disease some authorities believe belong to the same group of diseases and may have a common etiology. There had been reports of the high incidence of Dupuytren's contracture in association with it. The most effective dosage is 300 mg. daily given for at least six to eight weeks and often for much longer periods.

In 1947 Lowsley and Gentile[6] reported good results with surgical excision of the lesion. However, surgical excision may result in further scarring with worsening of the condition. Teasley[11] and Bodner, Howard, and Kaplan[1] in 1954 reported encouraging results with the use of oral cortisone and hydrocortisone-hyaluronidase injected directly into the lesion. This therapy was based on the known antifibroblastic effect of cortisone. Oral cortisone seems to be ineffective and carries the hazards associated with its use in any condition. The direct injection of hydrocortisone-hyaluronidase and fibrinolysins has not proven especially effective, and such therapy may result in further scarring with worsening of the condition.

Radium has been used in the treatment of Peyronie's disease for many years. In 1948 Fricke and Varney[4] used it in a series of cases from the Mayo Clinic. Almost 50 percent showed some degree of improvement. Results of this therapy at the Michael Reese Hospital Radiation Center from 1940-1960 are as follows:

Number of cases — 36
Average age — 54 (Youngest 26. Oldest 68. Two under 30 and the rest over 40)
Dose/Time — 900 mg. hrs. (4,500) /3-4 days
Results
Improved — 12
No change — 11
Lost to follow-up — 13

Improper use of radium may cause severe burns and atrophy of the penis. Radium therapy may be repeated after a six to eight week interval.

POTABA® (potassium para-aminobenzoate) is the most recent remedy recommended.[13] It has an anti-inflammatory and antifibroblastic effect. It cannot be used in combination with sulfonamides and, as is common with all potassium compounds, may cause severe cramps and nausea. POTABA may be taken as tablets or in a chilled liquid form. The daily dosage is 12 grams of ½ gram tablets (24 tablets a day). Our experience with this drug is limited to one patient in which it had to be discontinued because of severe nausea. It is a recent drug and needs further evaluation.

Topical applications of mercury, iodine, camphor, and iodoform; iodides and arsenicals internally; ultraviolet rays, short wave diathermy, faradic current, radon seed implantation, x-ray therapy, autogenous vaccines, and manual massage of the penis, all used in the past, are now recognized to have no merit.

Report of 37 Cases

From 1950 to 1960 we saw 37 cases of symptomatic Peyronie's disease and many asymptomatic cases that did not require treatment. Only 21 were followed for three months or more. Several patients had previously been treated by other urologists and since we had nothing more to offer, we were unable to obtain adequate follow-up. Only the symptomatic cases will be reviewed and only those 21 patients followed for at least three months will be included in the results.

Number of cases - 37
Average Age - 52.81 (Youngest 21. Oldest 76.)
Age Distribution - 20-30 - 1; 30-40 - 1; 40-50 - 9; 50-60 - 18; 60-70 - 7; 70-80 - 1.

Symptoms
Angulation of penis during erection - 37
Dorsal - 36
Ventral - 1
Painful erection - 17
Decreased libido - 12
Loss of potency - 4

Associated Diseases
Trauma - 4 (2 followed prostatectomies. One followed urethral dilatations for urethral stricture. One followed direct external trauma to penis.)
Prostatitis - 3
Benign prostatic hypertrophy - 2
Diabetes - 2
Dupuytren's contracture of hand - 1
Exposure to x-ray - 1 (21 year old x-ray technician)

Location of Lesion
Dorsum - 33
Dorsolateral - 3
Ventrolateral - 1

Method of treatment

Our method of treatment has been 300 mg. alpha-tocopherol in three equally divided doses daily for at least six to eight weeks and often for much longer periods. This is followed by radium therapy if there has been no improvement or if the improvement with the tocopherols becomes static.

Alpha-Tocopherol
"Cure"* - 3
Improved - 5 (2 of these patients developed a recurrence which did not respond to a second course of alpha-tocopherol therapy.)
No change - 5
Worse - 1

Alpha Tocopherol and Radium
Improved - 1
No change - 5
Worse - 1

**When using the word "CURE" in Peyronie's disease, it should again be emphasized that spontaneous regression of the lesion may occur making it difficult to evaluate the cure. One patient, followed almost 10 years, and another for 8 years have had no recurrence. One was followed for only 4 months.*

Summary

In conclusion, a discussion of Peyronie's disease with a review of 37 symptomatic cases seen over a 10 year period has been presented. The treatment will probably remain imperfect until the etiology is discovered. Peyronie's disease offers a challenge to the urologist.

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Trimester plan objectives

Considered strictly as a mechanieal system for dividing the calendar, the trimester plan provides for three fifteen-week terms. But within the past few years, this seheme has attracted considerable interest as an instrument of educational policy. Its advoeates see it as a means of facilitating the educational process and easing the growth problems facing universities in the years ahead. The conventional four-year undergraduate program followed by some years of professional study and training is regarded as archaic and wasteful both to society and the individual. Society is denied years of knowledge and service from its eollege and university graduates; the individual student is deprived of potential benefits at a stage of life when his intellectual and physieal powers are at their height. The trimester plan, say its proponents, enables schools to gear themselves to new social needs and demands by making more efficient use of time, human resourees, and physical facilities. Chancellor Litehfield of the University of Pittsburgh estimates that "35 per cent of our budget is with us whether we keep the doors open nine or eleven months." Moreover, the trimester calendar will help schools to aceommodate the burgeoning student population of the near future through greater use of physical facilities, thereby reducing eostly outlays for additional plant and faeilities that are sure to be staggering under conventional four-year programs. Thus the case for the trimester idea is based upon claims to gains that accrue from year-round operations. As a year-round system, the trimester ealendar offers a workable plan for cooperative programs, but so does the quarter system.

The University of Pittsburgh is an example of the trimester plan in operation. The Fall term opens early in September and ends prior to Christmas vaeation. The Winter term begins early in January and ends at mid-April. The Spring term opens shortly after the middle of April and runs through July. Vacations eome at regular intervals and August is a free month. As of now, faeulty members may teach two or three terms, but year-round teaching is already coming under criticism and is likely to be discouraged. Students may elect to attend fewer than three terms a year, but the whole idea of the plan is to encourage them to complete requirements for the B. A. degree in two and two-thirds years. Should a student then wish to undertake legal studies, for example, he may go on to complete requirements for his law degree in two years. Thus he fulfills the trimester objective of acquiring a liberal and a professional education within a span of four and two-thirds years. Under conventional programs he would spend seven years. *A Report to the University Senate on the Division of the Academic Year. Northwestern University. May 1, 1961.*



Some Problems Facing Britain's National Health Service

The Hospital Service

JOHN RECKLESS, M.B., Ch. B., *Durham, N.C.**

I CONSIDER IT a great honor to deliver the annual Camp Memorial Lecture. Dr. Harold Camp was a gentleman who served your society faithfully as its secretary for 35 years. As one who labored to maintain and improve this organization and what it stands for, he might well, were he able, indicate his approval for the subject of this lecture today. I sincerely hope so, for I intend to present some of the problems that are facing a nation which decided to adopt a system of compulsory, government-sponsored medical care. I hope that the experiences I present will be of interest to those who oppose a similar trend in this country's domestic scene.

State of Britain's National Health Service

Britain's National Health Service is here to stay. Whatever its critics may say, the plan which demands compulsory, government-sponsored financing and administration of the medical services is now an integral feature of Britain's national scene.

Since 1948 over 95 per cent of Britain's physicians and all but a handful of its hospitals have participated in the government-controlled health service. This is in three parts: a hospital service, a general practitioner service, and a public health service sponsored by local authority. It is directed by a minister of health, who is a senior politician appointed by the Prime Minister of England, to coordinate the various aspects of the service. The Minister of Health is directly responsible to Parliament and the people.

All citizens are required to belong. The service is financed by direct contribution deducted from the wage packet with the deficit made up from the national tax structure. The service is centrally controlled, with limited delegated authority at the local level. When it was first introduced in 1948, the following services were available at no extra cost to the user: complete general practitioner and consultant medical care; hospitalization and all the services that a hospital offers; all drugs and appliances; a complete system of sickness and disability, maternity and death grants; complete dental and ophthalmic care, and such supporting services as a home nursing and ambulance system.

Such was the demand that additional charges were levied on those who utilized the medical services, that is, on those requiring drugs, spectacles, dental care, and certain beds in the hospital system. The extra charges, were introduced in 1951, 1952, 1957, and 1961.

The Minister of Health's statement

Who could be in a better position to assess the service than the present Minister of Health, Mr. Enoch Powell? His statements quoted below will refresh those physicians in this country who oppose government-financed medical care, for he echoes with authority the fears which the American Medical Association expresses today.

In his first major speech after assuming office in the fall of 1960,[1] he stressed that the National Health Service, by its very nature as a comprehensive state service, holds dangers and possibilities of harm as well as opportunities and possibilities for good.

Speaking then of a centralized-responsibility and decision-making machine, he notes that the great danger is rigidity. "Policies which are formed centrally and executed administratively are bound to be slower to change and less adapt-

**From Duke University Medical Center.*

The Camp Memorial Lecture presented at the Annual Meeting of the Illinois State Medical Society, Chicago, May 17, 1961.

able to alterations of circumstances and demand, than if responsibility were diffused and decisions were independent. The great machine is bound to have a one-track mind, to be cumbrous and unresponsive, to abhor variations, to be insensitive to the world around it."

Now compare this candid declaration from the political minister controlling a state medical service with the declarations of those pressure groups in this country who want to move the direction and control of medical care away from the individual, private, and public sources at a local level to a government agency in the nation's capital.

Here are some examples of inflexibility in Great Britain. Hospital building has not met the demand;[2] the process of staffing the hospitals has deteriorated;[3] remuneration of the physician has not kept pace with inflation;[4] and expenditure on health has not kept pace with the amounts spent on other social services.[5]

Time does not permit me to outline the deficits in all these areas, but I would like to begin by discussing Hospital Building and to make comparisons between progress over the last ten years in Great Britain with its National Health Service and progress in the United States with its different system.

Hospital building programs compared

In the United States between 1946, when Congress authorized a National Hospital Survey and Construction Program, and Dec. 31, 1958, 184,900 hospital beds and 827 public health centers were being added to the nation's health plant.[6] The federal share amounted to just under one third of the total cost.

In Great Britain an estimated 447,000 beds were transferred to the National Health Service on the "Appointed Day" in July, 1948,[7] and at the end of 1958 there were 483,082 staffed hospital beds.[8] During a similar period then only 36,082 beds were added to Britain's National Health Hospital Service, while America built 148,818 more hospital beds, which even allowing for the population difference is an impressive figure.

Britain completed the building of no new hospitals in this period even though two out of three hospital structures were over 70 years old.[9] The Ministry of Health came into possession of a large number of hospitals, many of which were worn out and would have been worse except for the Trojan work of some local authorities who between 1930 and 1938 lavished large sums on trying to improve their own hospitals.[7] Capital funds during the first 12 years of the National Health Service have been niggardly.[9] D. S. Less[5] estimates that before World War II capital expenditure was about one fifth as large as current health expenditure; since the war it has been equivalent to only three or four per cent. According to Messrs. Able-Smith and Titmuss, the rate of capital expenditure up to 1952-1953 was below half the level needed to maintain the then existing stock of hospital beds.

These figures indicate that following acceptance by the government of responsibility for the nation's health care, there was a decrease in capital expenditure in the health services. Not only was there an insufficient expansion, but there was also, according to the above quoted statistics, an insufficient amount of money spent on maintaining the hospital structures existing up to 1953.

During the same period the United States saw over 600 new hospitals built, and many additional wings added to the existing plant. Since the hospitals in this country were newer, standards of comfort and convenience offered to the patient were much higher than in similar hospitals in Great Britain.

"British hospitals treat more patients than ever before"

I should now like to quote from the British Medical Journal of Sept. 10, 1960. "It is praiseworthy, that despite the inevitable financial difficulties quoted above, British hospitals have treated more patients than they ever did before and the over-all standard of work is undoubtedly much higher than in the past."

I quote this statement for two reasons. First, of course, it is proper to understand the benefits of the National Health Service, and secondly, this statement is often taken out of context and quoted in this country by those who support government-sponsored medical care. The inference is that if this country were to adopt a similar plan to the British system, a similar improvement could be expected.

But let us look at the other half of that paragraph from the British Medical Journal. "Although most of the credit is due to improved

staffing and wider diffusion of consultant services, tribute should be paid to the management committees that have transformed some derelict promises [see illustrations in reference number 7] and have improved facilities. Nevertheless the position is thoroughly unsatisfactory and the demands for a substantial increase in capital grants is thoroughly justified."[9]

British Hospital Service prior to 1948

No fair or valid comparison can be made between the hospital services in Great Britain prior to the introduction of the National Health Service and the present hospital system in this country. Those who point to the improvement in hospital services in Great Britain and offer this as an excuse for adopting a similar national health plan in America are not making a fair or valid comparison. Prior to 1948 the hospitals in Great Britain were old and poorly maintained due to the ravages of the war-time situation. A case was made for the government assuming financial responsibility for the hospital program. It is my impression that no such deteriorated situation exists in hospitals in the United States. To be sure, hospital administrators do complain of the difficulties and dangers of the rising price of hospital care; but through a combination of local effort and federal aid, the increasing demand for new hospital beds has at least been met. Such has not been the case in Great Britain, even with the government assuming full financial responsibility.

It has been estimated that 75 million pounds sterling should be set aside for capital expenditure for the hospital program. The amounts spent so far are

1955, £22 million;
1960, £25½ million;
1961, £31 million.

Although the government has pledged to increase this sum to £50 million by 1965, the demands are rising and show that there is a need for 40,000 more beds in the next 20 years and for 89,200 more beds by 1999.[10]

In January, 1959, the official U. S. state agencies estimated that an additional 867,000 beds were needed in this country. It should be, I think, completely understood that if the federal government takes over responsibility for the financing of medical care and follows the same pattern of decreased capital investment shown in Great Britain, then serious difficulties will arise in the future provision of hospital beds in this country. It should also be understood that the average bed-stay in Great Britain is substantially greater than in this country. If as a consequence of Congressional legislation the patient's financial responsibility for his hospital costs diminishes and the average stay increases, this could place a great strain on existing hospital-bed availability in the United States.

Of course, no one can say that the present pattern of considerable investment in capital expenditure on health service in this country would not be continued; however, in virtually every other nation where a compulsory national health service plan has been introduced, rising current expenditure has forced a cut-back in capital expenditure.

The significance of the unavailability of hospital beds is again shown in Great Britain. *A bed always exists if there is a definite, serious medical emergency.* The difficulty arises with a nonemergency situation, and the waiting lists are longer and are still rising. This, in the opinion of the British Medical Journal, is the most serious failing in the National Health Service today. A vast amount of relievable disability goes untended in such conditions as hernia, varicose veins, hemorrhoids, and prolapse.[9]

Consultant services

The other point, the improvement in the hospital situation being due to the diffusion of specialist services, should be mentioned, for again a difference exists between the pattern in Great Britain and that in the United States. Prior to the National Health Service, specialists lived by private practice, were limited in number, and were grouped around the larger hospitals. Today the pattern is more similar to that in this country, where more specialists are available and where the settlement is not just around the teaching centers but is spread, with the exception of a few specialties, throughout the countryside.

Needs of the aged and chronically sick

In the United States there now exists a considerable pressure to provide medical care for the aged through organization of the present Social Security system.[14] Some groups advocate federal intervention into medical care for the chronically sick. It is argued that this alliance

will allow more efficient care for the patients in these categories.

It is interesting to compare how these patient groups have fared under a system of compulsory government medical care. In November of 1960 the British Medical Association was asked to supply its opinion to a government-sponsored investigation by the Medical Services Review Committee (The Porritt Committee).[12] On January 28, 1961, the association's findings were published, and the responses were based on the survey within the framework of the British Medical Association.

I should like to quote some questions and answers:

Question 15: "Are present facilities for the care of the chronic sick and elderly patients adequate: in particular concerning admission to hospital of patients requiring (a) a long stay, and (b) a short stay for acute illness or for social reasons, and the admission of the dying? If not how may they be improved?"

Reply: "(a) No (b) No

"The facilities could be improved by closer integration and coordination of the various services and by improved Part III accommodation under the National Assistance Act, 1948 (Housing for Indigents). The provision of geriatricians, hospital beds, day hospitals, and hostels for the elderly should be increased. There is a place for a geriatrician and a geriatric service in all hospital groups. Hospital authorities should realize that there is a limit to the scope of domicilliary care, and they must accept greater responsibility for custody of the chronic sick.

"There is a real need for short-stay accommodation for social emergencies and also increased facilities for the transfer and reception of patients other than in general hospitals when the acute phase of the illness is resolved. There is a need for varying types of accommodation for many of those suffering from chronic illness, and there should be some segregation according to age, background and interests. Centers should be established in each region for the care of the young chronic sick."

Discussion

This reply offers real help to medical-care planners in the United States. It is apparent that with the diminished capital investment in the National Health Service no real effort has been made to build, equip, and staff the special treatment centers for the chronic sick and the elderly patients. The chronic sick do not need the acute-treatment facilities of a general hospital; they need rather the remedial services and after-care facilities. They and geriatric patients need convalescent facilities in specially designed buildings that avoid increasing psychologic problems imposed by their reduced mobility and loneliness. To house these patients in hospitals for the acutely ill is wasteful, both in terms of bed space and cost, for it costs much more to stay in a general hospital than in a convalescent home, and general hospital beds are needed for acutely ill patients.

Dr. Wilfred Fine, in a letter to the British Medical Journal dated March 18, 1961,[13] points out how, in many ways, the financial workings of the welfare state tend to disuade the family from the choice of home treatment and to encourage hospital treatment. In his letter he states, "The supreme example of this is the financial provision in relation to the aged sick in Great Britain." He points out that even following admission to the hospital, the patient's old-age pension, usually drawn for him by a relative, continues. He states that, in his experience, many families continued to draw the pension while the patient was in the hospital and, of course, the family was relieved of providing food and laundry for the patient. There is thus every financial inducement both to send aged relatives into the hospital, and once they are there, to keep them there. He further states, "When so many families, particularly in the lower income groups, are in debt to higher purchase firms, it needs no stretch of the imagination to realize the temptation placed gratuitously within the reach of needy relatives by the state."

When this argument is used by those who oppose the linking of medical care for the aged to the Social Security system, others point out that doctors are responsible for the length of time a patient stays in the hospital. This is an oversimplification of the case. If the relatives are not available or are unwilling to take care of an elderly patient who is over the acute phase of his illness but still requires some convalescent facilities, the physician faces an impasse. When the relatives are unwilling to reaccept the aged relative in the home, and when the physician realizes that though the acute hospital services

are not required, some further convalescent care is needed and that such care will not be provided outside the hospital, he has no option but to allow the patient to remain in the hospital bed. To arbitrarily discharge him would expose the physician to much criticism and place him in the center of unpleasant controversy. When such a situation is multiplied, it is easy to see how the hospital-bed turnover is reduced and the availability of hospital beds rapidly diminishes.

Care for the chronic sick and disabled in the U. S.

Now what has happened in the United States? In 1954 Congress broadened its hospital-building program to meet the need for long term care and chronic disability. Federal aid was authorized for the construction of diagnostic and treatment centers, nursing homes, chronic disease facilities, and rehabilitation centers. By Dec. 31, 1958, 612 new projects had been approved, including 226 diagnostic or treatment centers, 152 nursing home projects, 145 chronic disease hospital projects, and 90 rehabilitation facilities.[6]

It would again appear that under your system much more has been achieved.

What will happen in the future

In the United Kingdom in the next 40 years, the number of old people in the population will increase by 46 per cent among men 65 and over, and among women in the same age bracket by 34 per cent. A similar increase is expected in the United States, and it would be more appropriate to plan for their needs now under the present system of voluntary health insurance rather than open the doors of our general hospitals. The present trend of special hospitals for special patients which has been set by Congress over the past few years should continue. To increase current expenditure by opening the general hospital bed facilities for the care of the chronic and aged patients might, as stated before, reduce the amount of available money spent for building chronic and convalescent hospitals.

Medical research

Medical research is the key to the ultimate improvement of the nation's health. Its aim is the elimination of disease and the reduction of suffering in disability. Expenditure on research may be looked upon as a capital investment. Let us now compare how expenditure on medical research has fared in Great Britain and in the United States.

Again let us consider the Porritt Committee Questionnaire:

Question 22: "Do you consider that the existing facilities for research in (a) the hospital service, (b) general practice and (c) the Public Health Service are adequate? If not, please give suggestions for improvement."
Reply to Question 22: (a) No (b) No (c) No

The text of the answer is that there should be more sponsoring of research work by making more time and money available under the terms of the National Health Service.

To understand the differences between the two countries, on July 22, 1960, the parliamentary secretary to the Minister of Health reported the total expenditure on psychiatric research in the current financial year would be £200,000 (about $560,000) and that this sum represented 4.7 per cent of the estimated total budget of the Medical Research Council. This implies that the total research budget of the Medical Research Council, which is the major agency responsible for Medical Research in the United Kingdom, was about $12,000,000. Before proceeding to the American figures, it should be noted that some research is supported by private institutions and philanthropic organizations. Interestingly, the United States National Institutes of Health allocated $900,000 for medical research at universities and scientific institutions in Great Britain in 1960.[14]

One of the most impressive things in the United States is the amount of money devoted to medical research. In 1957 this was in the order of $330 million, of which the federal goverment provided $186 million, involving the employment of about 20,000 professional research workers. There are indications that this sum will rise to $1 billion by 1970. It is expected that the federal government will provide half of this amount; and private philanthropy, industry, and endowments, the remainder.[15]

It should be noted that in the United States before World War II research expenditure from all sources amounted to about $20 million. The question to ask ourselves is " In the event of a substantial increase in capital expenditure due to government intervention in financing medical care, for which an increase in general taxation

was deemed inadvisable, would there have to be a reduction in the amount of money spent on medical research?" The question has to remain open, but it does appear that in Great Britain the answer was *yes*.

Hospital staffing

In the two countries a shortage of junior hospital staff exists, but the way each country is handling the shortage is different.

In Great Britain it has been estimated that there are 9,543 junior grade doctors (interns and residents) and that they represent 40 per cent of the medical staffs of the hospitals. Over one third of them are qualified outside Great Britain (minimum 3,181) and without these doctors from overseas, a large number of whom are in Great Britain for a short time only, there would be a break-down of staffing below the senior registar grade (senior resident).[16] It is said that there is an inadequate number of specialists and that the specialist's responsibility is being excessively or inappropriately delegated by senior hospital medical officers, senior registrars, and members of the junior grades.[3]

The percentage of overseas doctors in the junior hospital grades is quoted in table 1.[16]

TABLE 1. Proportion of Total Staff in the Junior Grades in England and Wales Represented by Doctors Not Born in Great Britain.[16]*

Hospital Region	Proportion
Newcastle	51%
Leeds	50%
Sheffield	51%
Liverpool	36%
Manchester	49%
Birmingham	46%
East Anglia	45%
Metropolitan (four regions)	27%
Wessex	32%
Oxford	43%
South Weston	34%
Wales	37%

*Adapted.

What is being done to meet this situation? It should first be stated that in Great Britain few general practitioners have access to hospital beds under their direct control. When they have a patient who requires hospitalization, it is usual for them to refer the patient to a hospital where they are then taken care of by the appropriate specialist. The shortage of hospital staff is not due to a shortage of British physicians. Many general practitioners hold specialist medical qualifications, and they, with other general practitioners, would like to perform part-time hospital duties for their patients; but so far no provision for that has been made by the Minister of Health.

No shortage of British doctors

In a reply in Parliament, Mr. Walker-Smith replied for the ministry that in 1954-1955 the number of students entering medical school was 2,100, and 1,700 in 1958-1959. The Willinck Committee had suggested a reduction of 10 per cent in student admissions as soon as possible, and said that the Royal Commission in February, 1960, expressed a view that the supply of candidates with training as doctors was reasonably close to requirements. In addition, a minority report of the Royal Commission suggested that it was desirable to reduce the long lists of patients among general practitioners.[16] The most recent figures showing the number of applications for admission into medical schools in Great Britain, other than Oxford and Cambridge, as reported by the vice-counselors and principals of the United Kingdom, are even more interesting.[17]

	Application 1959 (To nearest 100)	Admission 1959 (To nearest 10)
England	10,800	1,170
Wales	300	60
Scotland	2,000	470
Total	13,100	1,700

In 1960 a further report by this committee showed that the totals had risen to 16,000 and 2,030 respectively.[18]

It has been suggested that the paucity of home graduates and the influx of overseas graduates into the junior posts is undoubtedly due to the fact that the latter will be able to use their increased knowledge and skill in hospitals in their own countries, whereas the home graduate on entering general practice will find the hospital closed to him and his skill unused.[19] The other interesting facet of the above figures is that beyond doubt the introduction of the National Health Service has not reduced the number of students applying for entrance into the medical schools. It is important to realize that in Great Britain there is no economic barrier for those wishing to enter medicine. One has to be of

TABLE 2. Cost of Great Britain's National Health Service.

Expenditure and Income	1949/50	1952/53	1954/55	1956/57	1958/59	1957/58
	(in millions pound sterling)					
Gross expenditure by Central Government	446	518	525	621	661	714
Hospital & specialist services	247	296	324	388	414	447
Financed by taxation	395	467	470	558	592	643
General taxation	354	426	429	516	527	538
National insurance & health contributions	41	41	41	42	65	105
Health service charges	3	20	25	29	33	33
Miscellaneous	48	31	30	34	36	38
Total Income	446	518	525	621	661	714

the minimum age and educational level to be eligible for a grant.

Staffing position in the United States

In the United States a similar problem exists with 12,942 foreign medical graduates listed in approved hospital programs on July 1, 1960.[20] Of these, 25 per cent are in the hospital service,[21] and 75 per cent work as residents and interns. In addition to the licensing of these physicians by the Education Council of Foreign Medical Graduates, other efforts are being made to increase the supply of medical and dental personnel in the health professions. In the period 1950-1958 six new medical schools were established and three more expanded from two- to four-year schools. Six new dental schools have been opened. It should be noted too that the present ratio of physicians in the United States, 140 per 100,000 population, is one of the highest in the world.[6]

Financial aspects

We have seen that the National Health Service in Great Britain and the medical care system in this country have had to face similar problems in the areas of capital investment, (1) hospital building, (2) hospital staffing and (3) research in the medical field.

In England the solution of the problems was less vigorous than in the United States. There can be little doubt that the motivation to solution was similar in each country. In the field of recruitment to medicine England seems to have an advantage; yet steps to increase the staffing of the hospital services leave room for improvement.

The difference seems to be one of finance. The Minister of Health stressed this in his reported speech, saying that finance was a great weakness.[1] Actual cost figures are shown in table 2.

The following facts emerge from the table: With the rapidly rising cost of the service, the increased revenue from payroll deductions in the name of the health service amounted to only £64 million while the less obvious increase from the general exchequer amounted to £248 million. The health service "extra" charges on those who obtained certain services rose by only £30 million. This means that those members of the general public who only reckon that the service costs the total of the weekly contribution plus the extra charge for drugs, etc., are deluding themselves and ignoring the substantially higher income tax rate levied to offset the deficit.

In February of 1961 the Minister introduced further "extra" charges on those who used the service and in plain words stated there must be a limit to what the state pays for its health service and that the balance must come from the consumer.[22]

"When the scheme started [Mr. Heathcoat Amory said] the intention was that these direct contributions should cover a fifth of all Health Service expenditure; and certainly there are advantages in the public paying from their wages and salaries a significant proportion of what the service costs—especially if they understand what that proportion really is. On the other hand, a fifth of the cost of the service in 1958 is much greater than a fifth ten years ago; and for some families the proposed subtraction of ten shillings from the breadwinner's paypacket (for National Insurance and National Health) will be about

as much as they can stand. The objection to flat-rate compulsory contributions as a means of financing national schemes is that they bear most hardly on those who have least money, and the Government's new requirements will be criticized for their further retrogressive effect. If more money is to be raised in contributions rather than by additional ordinary taxation, the time may soon come when it will be impossible to maintain the flat rate, and contributions will have to be related to income."[23]

The rise in costs of the Health Service has been alarming. Large supplementary estimates were submitted in 1949 and 1950, and the actual cost for 1949-1950 was 70 per cent greater than the estimated cost for 1948-1949.

Financial ceilings were imposed by Parliament in May of 1951; measures were designed to damp down demand and defray part of the cost. They were increased and extended in June, 1952, and again in December, 1956, and February, 1961. As you will observe from the figures shown above, general taxation bore the brunt of the cost.

Prior to 1938 health expenditure was two parts private and one part public. Today it is approximately 95 per cent public. This switch means, among other things, that the level of taxation is higher than it otherwise would have been. How much lower taxation would have been had the National Health Service not been established is impossible to estimate with any accuracy, but a reasonable estimate is £500 million (approximately $1,400,000,000). In perspective this means that the purchase tax (sales tax) could have been abolished or the rate of income tax lowered significantly in Great Britain. Economists maintain that had taxation been lowered, the great incentives to work, to save, and to cut costs and take risks would have raised total output and investment above the present level; and the lower taxation would have enabled the country both to enjoy the present standard of health services and to have additional resources for use in other directions. This is one of the public Health Service costs that is often overlooked.[5]

Financing of medical care for the aged under the Social Security system

The plan to link medical care financing for the aged to Social Security needs to be looked at very closely. "The Coming Din of Inequity" by Ray M. Peterson, vice president and associate actuary of the Equitable Life Assurance Society of the United States, published as a special contribution in the Journal of the American Medical Association, deserves to be read very closely.[22]

This article shows very carefully that Social Security is not "time-tested and proved" and does not possess "the many unique characteristics of voluntary private health insurance." This program depends for its safety and stability on the taxing power of the United States government; and if costs of a public health service soar as they have in most other countries, the increase in cost would either have to be transferred back to the consumer, as in Great Britain, or the services curtailed as they were in Australia when the list of available free drugs was sharply cut.

Financial future of the National Health Service

In February of this year the Minister of Health announced the increase in charges for persons obtaining dentures, spectacles, and many beds, prescriptions, and welfare foods through the National Health Service. In justification of the increase he stated, "the net estimates of the National Health Service and the Health Department for the next financial year indicated an increase of 11 per cent over those for this year. This followed upon an increase of over 8 per cent this year and over 6 per cent the year before. The total cost in the current financial year was about £869 million, of which £663 million would be met by the Exchequer.

"The government was determined," continued Mr. Powell, "to continue their policy of developing a Health Service and in particular to carry through a long term program of modernizing our hospitals. These objects would be in danger if the cost of the service to the exchequer were allowed to go on increasing at so high a rate. The government had therefore decided that certain steps to reduce the net estimates were necessary."[23]

The Minister of Health has coined the slogan "fewer beds in newer hospitals," and the shift of expenditure within the British National Health Service for the rest of the century may, perhaps, be away from the costly Health Service towards community and domiciliary services.[24] It is unfortunate that in the United States the administration's program will be directed to

moving the population, especially the aged population, from the home community care resources into the hospitals of the nation.

Questions for the American people

It cannot be denied, in the view of the experience in Great Britain and other countries, *that the introduction of government into the field of financing medical care will lead to changes in the doctor-patient relationship, the utilization of hospital facilities, the future expansion of hospital services in this country, and relationships between doctors themselves.* Physicians, therefore, have every right, and indeed the moral responsibility, to examine carefully the need for change in the present medical system in the United States. The answers to the following questions should be elicited and placed before the American people.

1. Are you convinced that a genuine need exists to cause such a transfer of responsibility for the financing of medical care to the government?

2. Do you think that the March, 1961 figures for private prepayment insurance, as quoted by the Health Insurance Institute,[25] reflect America's confidence in the present system and the willingness of the people to shoulder their own burden? (The figures are 132,000,000 persons carry hospital insurance, 120,000,000 surgical insurance, 86,000,000 have regular medical insurance, 25,000,000 have major medical care; and 43,000,000 have loss-of-income insurance. Benefit payments were estimated at $5.6 billion which was approximately 9 per cent above the 1959 payment to patients.

3. Do you think that private voluntary prepayment insurance, including the new plans which offer extended medical benefits to the old person, are sufficient to offset the need for government intervention into financing medical care?

It should be stated in answer to the critics who claim that it is humiliating for a person to have to go to a government agency and ask for public assistance to meet medical bills that even in Great Britain patients still have to go through this particular application. In a statement made in the House of Parliament in February of 1961, Mr. J. Boyd-Carpenter said that in 1958 the National Assistance Board refunded a sum of money representing over 19 million prescription items; in 1959, a sum of money representing over 20 million prescription items; in 1960, a sum also representing 20 million items. The number of applications rejected in these years were respectively about 3,000, 2,000 and 1,500.[26]

4. Should the Kerr-Mills Bill, which helped 14,800 persons in December, 1960, and 16,800 in January, 1961,[27] be given a chance to prove its worth before the administration forces the introduction in Congress of its present plan to link medical care for the aged with Social Security?

Conclusion

The fate of the present debate on the question, shall the cost of medical care for the aged be linked with Social Security, now rests with the people. In this paper I have attempted to illustrate some of the problems that have arisen with the compulsory government medical system in Great Britain. The bibliography shows a source of the fact and opinion I have used for illustration. I wish to point out that I have deliberately concentrated on areas where a problem exists and that I do not wish to minimize the other areas of benefit nor other difficulties that face those who run and are working in the National Health Service. On the other hand, the lesson which Britain has learned may well be useful in that similar problems should be avoided in this country.

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ISMS Committee Chairmen

WORKSHOP

Agenda:

- *Problems in administration*
- *Preparation of reports*
- *Suggestions from 1961 House for committee activities*
- *Committee policies, responsibilities and programs*

Sunday, Sept. 17, 9 a.m. **Drake Hotel**

Chicago

Heredity, Diet, and Coronary Heart Disease

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The presence of coronary heart disease in a given patient must usually result from several influences. Suspected factors are numerous: diet, physical activity, stress, occupation, personality, hormones, blood lipids, vascular anatomy, arterial wall enzymes, trace metals, lipid transport systems, and blood coagulability, to name a few.

It is worthwhile to note that many of these should reasonably be under genetic control. Support for this view can be found in both a specific and a general way. For example, Adlersberg has shown that even modest hypercholesterolemia will follow a familial pattern, and that the genetic mechanism for this is in accordance with a gene which is dominant but incompletely penetrant.[1] Furthermore, the basic mechanism for setting normal or abnormal cholesterol levels in general is inborn, as judged from family and twin studies. More broadly, the reports of Epstein et al. indicate an ethnic difference in coronary heart disease between Jewish and Italian males, the former being twice as frequently afflicted in those sampled.[2,3] The two racial groups seemed unusually comparable in other ways: occupation, socioeconomic status, diet, blood pressure levels, relative weights, and incidence of diabetes. This study also showed a higher incidence of coronary disease among the Jews even when a "low serum cholesterol" Jewish group was compared to a "high serum cholesterol" Italian group. Here, then, is evidence that other inherited traits may also be determinant in the development of coronary disease.

A common clinical observation is that coronary heart disease appears to plague some sibships and not others. Thomas and Cohen, in an evaluation of offspring with a mean age of around 55, showed that 21.2 per cent were afflicted with coronary heart disease if *both parents* had been afflicted.[4] If *neither parent* had coronary heart disease, only 4.1 per cent of the offspring were affected. Where only one parent was positive, the percentages for the offspring fell between these extremes. Further evidence for a familial factor is seen in Russek's data wherein 67 per cent of 100 young coronary patients had a heritage of one or both parents being affected by "cardiovascular disease," contrasted to 40 per cent of control patients.[5]

Clearly, then, heredity is a factor of at least some importance in this illness. But this leaves much unsaid. We should like to know, for instance, whether there are not many specific traits which weaken or strengthen the tendency to coronary occlusion with myocardial infarction, and just what these traits are. As each factor is studied in etiology, it will be helpful to assess its genetic characteristics. Some inherited traits are amenable to environmental control; and since those traits having to do with coronary artery disease appear to gain greater influence with advancing age, perhaps there are ways of forestalling clinical illness by accurately selecting susceptible persons early for prophylaxis of their inheritance. The preceding example of hypercholesterolemia being "incompletely penetrant" speaks to this point; here is a genic excess that can be modified in many ways.

Diet

There is certainly ample evidence that proper dietary control can lower serum cholesterol. In addition, the presence of hypercholesterolemia as a factor in coronary artery disease is hard to ignore. Therefore, if one will accept a role for elevated cholesterol and/or other lipids in this illness, it is important to note that something can be done about it, even though genetic mechanisms are operative. In other words, a familial tendency to hypercholesterolemia (and hence to

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coronary artery disease?) can be counteracted by diet and other means. By restricting cholesterol intake, for example, it may be that the metabolic system(s) controlling circulating cholesterol will not be pushed beyond their capacity.

Awaiting explanation is the frequent disparity between the extent of atherosclerosis found in the coronary vessels of a patient, and the presence or absence of myocardial infarction. This has led to the assumption that although the processes of atherosclerosis and myocardial infarction are related events, they are yet distinct; and one is left wondering why one individual dies of infarction with coronary arteries that grossly appear superior to those of other autopsied cases without infarction. These two processes, sclerosis and infarction, are not segregated in the genetic studies reported, and obviously it would require much detailed autopsy data to do this. Such information might partially elucidate where the genic influences operate. Areas to be explored are the location of the atheromata; whether they are diffuse or patchy; their tendency to vascularization; and how much sclerotic reaction the artery shows. The fact that a blood clot forms in a coronary artery might also be under some kind of genetic influence, and needs similar investigation.

In time, emphasis may shift to the study of those who are more or less immune to the clinical manifestations of coronary artery disease. Conceivably, there is information here of a positive nature which could be simulated by appropriate therapy in the individual who lacks a favorable inheritance.

Clinical application

At present the physician is correct in viewing a positive family history of coronary heart disease as a detrimental bias for his patient. The same statement applies to hypertension and diabetes, both predisposing to coronary heart disease in the progeny.[4] It is not possible, however, to decide how strong the disposition is in an isolated case; this must await the development of specific clinical measurements that have been shown to have genetic consequence. Nor can precise mechanisms of transmission of this illness be derived from present data.

Recognizing these deficiencies in our knowledge, the physician must also avoid the assumption that a patient who has a negative family history is necessarily spared from coronary heart disease. In fact, current data on the genetics of this illness are so meager that any preventive measures that appear helpful, including diet, should be extended to all persons, regardless of their apparent heritage. We cannot really select those who will prove to be immune.

Finally, the attention herein given to heredity in no way minimizes the importance of all the possible environmental factors in coronary heart disease. On the contrary, it is hoped that as individual hereditary elements are identified, they will also yield to exogenous control.

While the Nutrition Committee of the Chicago Heart Association is sponsoring this article, the opinions expressed are those of the author and do not necessarily represent the official view of the committee.

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When you cannot make up your mind which of two evenly balanced courses of action you should take—choose the bolder. — *W. J. Slim*



Cook County Hospital

Strangulating Obstruction

Moderator:
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Discussants:
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Dr. Robert J. Freeark: Few problems in all of medicine remain as vexing and controversial as the subject we have chosen to pursue this morning. Few people are as qualified as our guest to undertake the discussion of this topic, for Dr. Harold Laufman has been closely identified with the problem of strangulating obstruction throughout much of his distinguished surgical career. A significant portion of what is known about the pathologic physiology of this condition is the result of his careful clinical and experimental observations. At the request of the American College of Surgeons, he and his associates have recently completed an educational motion picture dealing with this problem. It was our distinct pleasure to assist him in this endeavor, and one of the cases depicted in the film was photographed by the resident staff here at County.

Dr. Laufman has kindly consented to join us today and to project this film. As a former member of our staff, he knows well the trials and tribulations inherent in the management of patients who enter this institution. We have selected as the basis for discussion the case history of one of the patients seen in the film. The regrettable outcome in this case must serve as a grim reminder of the distressingly high mortality rate that continues to be associated with gangrenous bowel obstruction.

Case history

Dr. Ralph Bransky, surgical resident: A 48 year old Negro woman was admitted to the hospital at 2 a.m. on April 28, 1960, with complaints of constant pain for three hours in an umbilical hernia. Several episodes of bile-stained emesis had occurred since the onset of pain. The hernia had been present for 12 years and had first appeared after the birth of a child. It had never been symptomatic previously, and the present complaints were provoked by a coughing spell. The remainder of the medical history was noncontributory.

Physical examination revealed an obese short woman with considerable pain over the hernia. Her blood pressure was 140/100 mm. Hg, pulse 80 per minute, temperature 98 F., and respirations 20 per minute. A grapefruit-sized mass in the region of the umbilicus was tender and discolored, and efforts at reduction were unsuccessful. There was mild distention, and the bowel sounds were hypoactive.

The positive urinary findings on admission were a 3 plus albuminuria and specific gravity 1.005. The hematocrit was 41 per cent, WBC 9,000.

Seven hours after the onset of illness and four hours after admission to the hospital, surgery was performed through an infraumbilical incision, with excision of the sac and closure of the fascial ring using interrupted wire sutures. The hernial contents were considered to be viable and were replaced in the abdominal cavity. A drain was placed at the edge of the wound down to the fascial closure to prevent subcutaneous fluid collections. Initially the patient appeared satisfactory but by nine hours after surgery she had developed a temperature of 106 F. rectally, pulse 136 per minute, and respirations 36 per minute. Her blood pressure was 150/90 mm. Hg. She was quite obviously in a desperate condition, and copious amounts of dark serosanguinous drainage were observed, exuding from the drain in the wound. Approximately 11 hours after the first operation the patient was returned to surgery where the primary wound was opened under local anesthesia and nine feet of gangrenous small bowel were identified. The necrotic bowel extended almost to the ileocecal valve so that resection was undertaken with closure of the distal ileum and continuity restored by ileotransverse colostomy.

The condition of the patient following this procedure remained poor. She was treated with plasma, whole blood, fluids, Levine suction antibiotics, and hydrocortisone. She had intermittent coffee-ground emesis or drainage per Levine tube. Melena started on April 29. Hydrocortisone, which was instituted because of intractable hypotension, was stopped by May 2, but intermittent upper gastrointestinal bleeding persisted. Her course was further complicated by the development of bilateral basilar pneumonitis. By May 4 upper gastrointestinal bleeding became more vigorous, and she required two more units of blood. Conservative measures failed to arrest blood loss, but attempts to prepare the patient for re-exploration for gastrointestinal bleeding failed, and she died on the evening of May 6 after a hospital stay of nine days.

Dr. Freeark: I shall withhold the postmortem findings until we have had a chance to review the clinical course. Dr. Laufman, will you give us your impressions on this case?

Dr. Harold Laufman: I think we should proceed immediately to the film because it will introduce the subject, and I believe we can take up some of the individual points later.

(Movie shown here with comments as follows.)

Strangulating obstruction of the intestine is an intriguing condition from a clinical and experimental point of view. It stands as a diagnostic challenge in every case of intestinal obstruction because, if it is not recognized, undue delay may prove disastrous. Once it is recognized, the judgment used in preoperative, operative, and postoperative management must be guided by what is known about the pathologic physiology of the strangulating lesion. Errors in judgment are largely responsible for the high mortality rate.

Strangulating obstruction remains something of an enigma for those who seek to clarify the factors responsible for death, but much has been done experimentally so that today the mortality of strangulating obstruction need not be higher than that following other acute intra-abdominal lesions.

The diagnosis of strangulating obstruction is justified whenever intestinal obstruction is complicated by compromise of the blood supply. For many years it has been known that the cause of death is not the same in all cases, although certain pathologic features are common to all. Regardless of the type, the survival of the patient is inseparably dependent upon a prompt and effective surgical attack. There is little doubt that the judicious use of antibiotics has contributed to the success of surgical management and represents a more recent advance in the management of this problem.

Examination of the available clinical and experimental data indicates three major sources of error in the surgical management of strangulating obstruction, correction of which could lower the mortality rate. These are (1) undue procrastination in performing surgery, (2) reluctance to resect bowel of questionable viability, and (3) inadequate or improper use of blood, plasma, and electrolyte solutions. In the film you are about to see, an attempt is made to demonstrate these points by means of clinical, experimental, and graphic material.

The commonest type of strangulated hernia is the external inguinal variety which results in a loop strangulation. Internal hernias are more difficult to diagnose. One type occurs in the

various recesses about the duodenum and are called paraduodenal hernias. A particularly treacherous variety of hernia is the Richter's type, in which only a portion of the bowel wall is trapped in the hernial sac. Not only is the obstruction often incomplete but the entrapped wall may rapidly undergo infarction and secondary rupture. In any process impairing the venous or arterial circulation to the bowel wall, bacteria rapidly permeate this barrier, and necrosis eventually occurs in the wall. On histologic study of experimental obstruction, after only one hour, disintegration and rupture of the mural structures occur. The tension built up within such a loop mounts rapidly, and the only treatment is resection.

The next series depicts the accumulation of bacteria at the area of weakness and the rapid progress of bacteria through the intestinal wall. These events begin when intraluminal pressures exceed the venous pressure in the involved loop of intestine. Very early there is dilatation of the lymphatics within the mucosal area carrying bacteria into the mural structures long before the bowel loses its viability.

The blood vessels of the mesentery are interesting. As the venous blood pressure mounts, there is dilatation of the veins and rupture of some of the small veins. The microscopic appearance of blood vessels in the mesentery shows that if the vein is dilated, the artery goes into compensatory spasm. With release of such a stragulation the artery remains in residual spasm for a variable period of time, a factor of some importance in the recoverability of bowel.

The peritoneal fluid has been the subject of considerable investigation. Early the fluid contains no blood and few bacteria. In 30 minutes the intraperitoneal fluid is more cloudy and blood-tinged. After 45 minutes the mesentery becomes infiltrated with blood and fluid and is thickened and rubbery. On histologic study the bowel is still quite viable, although the wall is thickened and fluid is beginning to accumulate there. The blood infiltrates the mucosal structures first and later involves the submucosa. At 45 minutes the intraperitoneal fluid contains more blood and is contaminated with bacteria. It contains fibrin, and clots readily.

Early in the course of strangulating obstruction, hyperperistalsis is observed in the involved loops. This is a response of the bowel wall to anoxia. After one hour the hyperperistalsis has diminished to some extent. The mesentery can be seen to be more involved than the bowel loop, and there is greater infiltration of the blood in the mural structures. At 90 minutes the mucosal structures lose all semblance of viability and become extremely blood- and fluid-soaked and quite contaminated, and yet there is some peristalsis present. Strangulated bowel which has undergone slow strangulation at first and then rapid strangulation leads to a degree of destruction of tissue more extreme than occurs with rapid strangulation alone.

If one cultures the mesenteric venous blood at intervals, one can find that these vessels contain a large number of bacteria. Culture of the mesenteric venous blood at 45 minutes of strangulation reveals beginning accumulation of bacterial growth; at 90 minutes there is heavy growth of bacteria, and five minutes after release of the strangulation the bacteria are washed out into the portal circulation. This may account to some extent for the occurrence of shock after release of a strangulated segment.

This problem of shock in strangulating obstruction is not an easy one to resolve. One must constantly keep in mind the nature and magnitude of fluid losses that occur in the involved loops. Where the segments of bowel are long, the loss of blood and plasma into the tissues as seen under the microscope are not inconsiderable. In addition, blood and plasma is lost into the free peritoneal cavity or hernial sac and rapidly becomes contaminated with bacteria. The replacement of blood and plasma is essential to the rehabilitation of the patient for surgery. Loss of effective circulating blood volume is further diminished by the bacterial and endotoxin invasion as well as by the fluids and electrolytes lost in the vomitus or into loops of paralyzed bowel.

The clinical picture in strangulating obstruction is a highly variable one. Often the suddenness with which it begins and progresses in some patients does not suggest intestinal obstruction. In others, the classic symptoms — obstipation, distention, vomiting, and intermittent cramping abdominal pain encountered in uncomplicated or simple obstruction — progress in a very subtle fashion to a picture of peritonitis and circulatory collapse. In the latter

instance a very important clue is the persistence of pain between cramps usually perceived in the periumbilical area or in the lumbar region posteriorly.

X-ray study in these patients may or may not be rewarding. Usually the routine abdominal views reflect a picture of mechanical obstruction with loops of dilated proximal bowel containing air and fluid with little air demonstrable in the colon distal to the point of obstruction. Occasionally, the scout film may show a large area of increased density which represents fluid-filled loops of strangulated bowel and has been called a "pseudotumor."

At the time of surgery innumerable problems may arise. In long loop obstructions there is occasionally difficulty in determining accurately between viable and nonviable bowel. There may be only a gradual transition, and it is occasionally necessary to resect at even greater distances in an attempt to obtain bowel of unquestioned viability.

In short loop obstructions such as occur in femoral hernia, the site of the constriction ring requires careful assessment. A narrow band of necrosis may exist through which bacteria may permeate and lead to peritonitis. Even if peritonitis or intestinal perforation does not occur after return of the intestine to the abdominal cavity, adhesions may be marked, and a secondary or delayed obstruction may result.

Another complication following release of what appears to be viable bowel is propagation of thrombi in the mesenteric veins leading to delayed gangrene several hours after surgery. This is apparently what occurred in the patient whose history was presented earlier. At the second operation one sees a long loop of obviously black bowel. The resected specimen showed the severe involvement 11 hours after replacement of apparently viable intestine into the peritoneal cavity. Such a course is typical of progressive mesenteric thrombosis in the veins of involved loops. Careful assessment of these mesenteric vessels is essential even though the intestine which they nourish appears healthy. Long loops of this intestine at times must be resected in order to avoid this delayed vascular accident.

Dr. Freeark: That was a magnificent presentation of what is obviously a very difficult subject. The patient depicted in the movie is the case history outlined in the protocol. I would point out that a very capable resident handled the case initially and his ability to assess viable bowel I believe is excellent. This would indicate, as Dr. Laufman pointed out, that progressive changes may occur some time after the bowel is adjudged viable and returned to the abdominal cavity.

A second point concerns the fluid losses both into the infarcted and obstructed intestine as well as into the free peritoneal cavity. We have already described the copious amounts of fluid that poured from this wound both before and during the second operation. A hematocrit was obtained on this bloody fluid and was shown to be 7 per cent. Its protein content, however, was exactly that of plasma, about 7.5 Gm./100 ml. You can readily understand the great concern and current emphasis upon adequate replacement of fluids and plasma in such patients. This fluid gushed forth in unbelievable quantities from the abdominal cavity.

Dr. Laufman: There are several additional clinical points I would like to emphasize. Let us first consider the patient without a palpable external hernia who has signs of intestinal obstruction. It now behooves you to discover whether there is impending or actual strangulating obstruction or merely simple obstruction. The only fairly reliable sign that I know of — and the one this is virtually uniformly true — is persistence of pain between cramps. This is in contrast to the patient with simple obstruction who has a severe cramp and distention but no great discomfort until the next cramp comes along. In strangulating obstruction there is intense pain that persists. In a person with a long loop obstruction, particularly when there is mesenteric vascular occlusion, the abdomen is not too distended and not too tense. It may be doughy but is usually very tender.

Another sign is the white count which may rise to levels way out of proportion to the clinical appearance of the patient. A count that goes to 20,000 is not part of the picture of simple obstruction.

If, however, one deals with a patient who has obstruction and a palpable hernia on the outside, one deals with a situation in which there should be no delay. Strictly speaking, there

should be no great delay in patients with internal hernias either. I would disagree with some surgeons who say that they prefer 24 hours of good nonoperative management, and that if the patient does not get better in that time, then it is time to operate. I do not subscribe to that. I say that a patient who has out-and-out signs of mechanical obstruction and who can be brought into satisfactory condition for surgery, should be operated upon promptly. One possible exception is the patient with the recurrent obstruction who has a belly full of adhesions and has been operated upon before and has an obstruction again. That patient may often best be treated conservatively.

These are variations on the main theme. One cannot generalize altogether. If one is confronted with a patient — and I do not care how many laparotomies he has had — if that patient has pain between cramps, I think surgery should be contemplated very soon.

One of the problems with our entire management, and one of the problems that occurred in this patient whose history you heard, is our inability to judge blood volume. We have installed recently at Passavant Memorial Hospital a new machine, the Volemetron, which gives blood-volume determinations in six minutes. We knew from our work on animals that the amount of blood and fluid lost in patients with strangulating obstruction was great, but we had no measurement of this in humans. A patient with a loop strangulation such as the last patient, with six to eight feet of bowel that has been strangulated over a period of seven hours, might well lose 60 per cent of his circulating blood volume. That may seem unbelievable, but it is true. You do not realize these things until you measure them, so that clinical assessment of blood volume is not too easy when you are forced to rely upon indirect measurements of blood pressure, pulse, hematocrit, and urinary output.

The use of cortisone seems ill-advised in these cases. Its role in severe shock has not yet been defined, but I believe this patient probably died of cortisone-activated bleeding; and I would not use it because of this ever present danger. Blood, plasma, fluid, and electrolyte deficits, circulating bacteria, and their endotoxins adequately account for shock, and it is unnecessary to assume adrenal cortical insufficiency.

Now I have a few slides I should like to show. They will show a loop of bowel of questionable viability that was almost returned to the peritoneal cavity until the base of the mesentery was studied and thrombi were found in the veins. (Slide) Here is a loop of pretty good looking bowel. This was a long loop strangulation. You find a few dusky spots in the serosa, but it does not look too bad, and one would be tempted to sit this out, particularly since the involved area was several feet long. Here is how it looked after it was released. (Slide) At the base of the mesentery, we see thrombi. We immediately resected this bowel because we did not want to risk the occurrence of progressive venous thrombosis.

Dr. Freeark: Dr. Edward Saltzstein, one of our senior residents, and Dr. William Marshall, formerly of our resident staff, have put in many long hours reviewing the records of Cook County Hospital concerning our experiences with strangulating obstruction. At this point I would like to have Dr. Saltzstein present some of this information.

Dr. Saltzstein: An occasional case of gangrenous bowel obstruction has been noted here in which dramatic response of a previously intractable shock-like state has accompanied clamping of the segment or excluding it from the circulation. It has been this occasional occurrence which led us to review cases of gangrenous bowel obstruction at this institution. We were unable to prove any statistical correlation between clamping of intestine and a response to shock, and we were unable to draw any conclusions as to the presence of an endotoxin active in human gangrenous bowel obstruction. However, several interesting facts did evolve.

We reviewed 100 cases of gangrenous bowel obstruction encountered during a period from Jan. 1, 1955, to Jan. 1, 1960. This was a selected series in which the pathologic interpretation of resected specimens were unequivocally hemorrhagic infarction of bowel. All cases of clinically or pathologically questionable viable bowel were excluded, as were cases in which other gastrointestinal problems were prominent, e.g., gangrenous colitis. Also excluded were newborns, and cases in which the clinical record was inadequate or incomplete.

The 100 cases include 36 of adhesive small bowel obstruction, with a mortality of approximately 30 per cent and 45 cases of external hernia with a mortality of about 50 percent. The over-all mortality for the 100 cases was 41 per cent. All these figures are higher than most reported series, and we believe this is related to the selection of cases.

Particularly impressive was the incidence of shock in the 100 cases. While difficult to define, we arbitrarily determined three groups, i.e., uncompensated shock, compensated shock, and no shock, as follows: Patients in uncompensated shock exhibited a pulse greater than 100 per minute, and a blood pressure less than 100/60. In compensated shock, the blood pressure was greater than 100/60 with a rapid pulse. Patients not in shock had a blood pressure greater than 100/60 and a pulse rate less than 100 per minute. There were sixteen patients in uncompensated shock, and none of them could be adequately resuscitated preoperatively with fluid and electrolyte therapy. Approximately one half of the patients were not in shock preoperatively, emphasizing the fact that vital signs are an unreliable criterion for evaluation of the presence or absence of gangrenous bowel. The patients in uncompensated shock had a mortality of about two times those not in shock.

Among the three groups we found a signficantly higher mortality over the age of 60, whether or not the patient was in shock.

Patients were also studied with reference to the time interval between admission and surgery; we chose the time of admission to the hospital as being more constant than the onset of symptoms, primarily because of the unreliability of the history. Mortality rates were appreciably lower if the patients were operated upon six and especially four hours after admission. Also noted was a rather constant mortality for each shock group after six hours and up to 48 hours. However, for any particular time interval between six and 48 hours, those in shock had a significantly higher mortality than those not in shock. Therefore, we feel that prolonged conservative management of the gangrenous bowel obstruction is not productive of higher mortality rates unless shock supervenes.

The next set of statistics relates to the amount of bowel resected. There is an increased mortality rate with an increased amount of bowel removed. In this group we noted that the presence or absence of shock did not affect mortality rates as directly as in the previous statistics.

The last group of statistics deals with the hematocrit. In this group we found that the hematocrit was not related to prognosis. Thus, a patient with a high hematocrit had the same chance of surviving as one with a low hematocrit. The value of a hematocrit lay in directing the course of fluid and electrolyte replacement.

Dr. Freeark: A statistical and detailed analysis of this material is still in preparation, but upon its completion, I believe it will be a real contribution to the surgical literature. The rewards to the authors personally are even greater because they gained in insight and knowledge of this problem. They have served to emphasize again the alarming mortality rate in these cases as well as the ominous significance of a shocklike state and the difficulties in assessing what is responsible for it.

Dr. Laufman,will you discuss the problem of shock in strangulating obstruction? In our experience it does not relate to the length of segment of intestines that is infarcted. What about endotoxic shock? Is the endotoxin the mysterious factor responsible for some cases of circulatory collapse?

Dr. Harold Haley: (associate attending surgeon) Suppose you have a patient with a grapefruit-sized, discolored mass in the region of the umbilicus which is tender. What would you recommend in this patient if efforts at nonoperative reduction had been successful, or if, as we occasionally see, the mass of this type reduces spontaneously. What would be your next step?

Dr. Laufman: I think it is one of the unknown factors. Shock can come from several sources. We know this from clinical experiences substantiated by laboratory work. Extreme distention can cause shock. In most cases it is the result of loss of fluids and blood. It may, however, be due to absorption of toxins, but we are firmly convinced that bacteria alone are not as great a hazard as bacteria plus dead or dying tissue. There is some enzymatic reaction that occurs, and it occurs out of all proportion to the simple addition of bacteria or dead tissue

alone. I think this never could be shown statistically unless one could have a series large enough to distinguish between the numerous causes of shock. In practice, we have to do the one thing we can do: relieve obstruction, take out dead tissue, fight bacteria, and reconstitute blood volume.

Dr. Freeark: As Dr. Saltzstein indicated, we have occasionally observed dramatic instances in which sudden clamping of the mesentery of the involved intestine was associated with rapid control of previously intractable shock. Just getting that loop of bowel out of the abdomen appears to reverse the shock state.

Dr. Laufman: I believe these situations are often overdramatized. By the time the clamp is put on there has been blood replacement and stabilization of physiologic data, and the patient is in better condition. However, I also believe that occasionally there will be rather sudden improvement with the clamping of the mesentery and removal of gangrenous bowel. This would point up the absorption of toxins as one of the factors in shock.

Dr. Laufman: The critical point is the fact that the mass is discolored. If this is present, then I would not attempt manipulative reduction. If it is a strangulated hernia, it will not reduce with manipulation that is gentle. If it should reduce with gentle taxis or spontaneously, the patient had better be operated upon, under local anesthesia if need be. If there is any evidence of discoloration under the skin in such a hernia, no attempt at reduction should be made because discoloration means there is bloody fluid in the sac, and this suggests strangulation.

Dr. R. C. Giles, (attending surgeon): Are radioactive isotopes of value in assessing the viability of injured intestine?

Dr. Laufman: I would say no. You recall that many years ago we went through tests for viability and came up with surface temperature determinations as a reliable guide to healthy bowel. We now believe that any extraordinary time consumed at the operating table to await the return of viability is perhaps not wise. I would not apply anything fancy like fluorecein or radioactive isotopes, because the loss of time these tests entail endangers the patient's life. The important question is How does this bowel look after it is released. If it is dusky and spotty and the blood vessels contain clots and the mesentery is bloodshot, I would take it out. We know now that if there is the least doubt of viability, it is better to undertake resection than to lean toward the "conservative" side. Then at least you won't have to worry about whether that bowel is going to turn dark a short time after the abdomen is closed. In good surgical hands, as resection is practiced today, it is not a very risky operation.

Question: Suppose you have a patient with intestinal obstruction who is in shock. You obviously do not want to operate until he is out of shock; yet heroic efforts have not succeeded in restoring his vital signs. What is your management?

Dr. Laufman: I would treat him as rapidly and intensively as possible. We cannot wait forever because the condition tends to become irreversible, but if after giving blood and fluids and antibiotics and intestinal decompression, we still do not have the patient in suitable condition for surgery, one must decide whether to let the patient die without surgery or operate under local anesthesia in an attempt to better the patient's condition by releasing the obstruction and removing the offending lesion. I would choose the latter course.

Question: How long would you pursue this intensive preoperative treatment?

Dr. Laufman: It is not easy to generalize. It depends upon what I have done and how the patient has responded. If the circulating blood volume is extremely low and I have replaced everything I thought he needed, and the patient just does not respond — this may take four to six hours — I would operate, if need be under local anesthesia. You cannot replace 2,000 cc. too fast. It takes an hour or two at least. If you replace it too fast you can kill the patient. Furthermore, it takes some time to be sure your diagnosis is right. The patient may have had a coronary after he became obstructed, and this may be a factor in his shock. It depends upon what you are dealing with — both the general condition of the patient and the severity of his problem.

Dr. Robert J. Baker: Have you had occasion to make bacterial studies of mesenteric venous blood in man as you have in the dog?

Dr. Laufman: No, we have not documented that in man.

Dr. Freeark: The autopsy study on the patient presented was not particularly revealing. The remaining intestine appeared viable, and all anastomoses were patent and intact. A satisfactory site or explanation for the upper gastrointestinal bleeding was not demonstrable. No definite peptic ulcerations were identified, and the cause of death appeared to rest with a combination of factors which included anemia, pneumonia, and the innumerable residual effects of a prolonged shock-like state.

We are indebted to you Dr. Laufman for this fine movie and presentation on one of the more puzzling problems in surgery.

Summary and conclusions

1. Interference with the blood supply of a segment of intestine accounts in large measure for the continued high mortality rate of intestinal obstruction. This interference may result from primary disease of the vessels, e.g., mesenteric thrombosis; primary disease of the bowel wall, e.g., regional ileitis; or more commonly a combination of factors encountered in incarcerated hernia.
2. Strangulation rarely occurs in large bowel obstruction except in volvulus. In contrast, strangulation is a constant hazard in all small bowel obstructions. While incarcerated hernias account for the majority of such cases, their prompt recognition usually facilitates definitive care.
3. It is in cases in which the diagnosis of intestinal obstruction is in doubt or those obstructions in which nonoperative management is elected, that pose the greatest threat of strangulation.
4. The presence of strangulation should be suspected in:
   a. *Any patient with abdominal laparotomy scars* and the sudden and dramatic onset of abdominal pain.
   b. *Any patient with bowel obstruction* in whom:
      1. The pain pattern becomes constant
      2. Pain radiates to the area of the lumbar spine
      3. Abdominal tenderness develops particularly with "rebound"
      4. Hematocrit above 50%, temperature over 101 F., pulse over 100
      5. Bowel sounds become infrequent or are absent
      6. Localized tenderness develops
      7. A boggy tender mass becomes palpable
      8. A shock state supervenes

   None of the above are consistent with the diagnosis of uncomplicated or simple intestinal obstruction.
5. Reliance upon the laboratory diagnosis of strangulating obstruction is the surest way to invite disaster. It is important to remember that in close to one third of all cases of strangulating obstruction, the routine views of the abdomen are interpreted as normal. In the cases in which you need it the most, x-ray study offers the least.
6. The development of a shock-like state associated with intestinal obstruction is an ominous sign of controversial origin. Clinical shock may result from simple obstruction as a result of dehydration, specific electrolyte disturbances, or the sequelae of marked abdominal distention. Its early and more frequent (50%) occurrence in strangulating obstruction is felt to be on the basis of a toxin of bacterial origin elaborated by the involved intestine and gaining access to the systemic circulation by transperitoneal absorption.
7. While a short period of nonoperative management may be indicated for intestinal obstructions resulting from previous laparotomies, persistence in this treatment beyond 24 hours or its application to other forms of obstruction invites strangulation and quadrupled mortality rates.
8. "In acute abdominal emergencies the differences between the best and the worst surgery is infinitely less than that between early and late surgery, and the greatest sacrifice is the sacrifice of time." H. Ogilvie

Preauricular and Cervical Cutaneous Appendages

Walter W. Silberman, M.D.,* *Chicago*

Many parents are concerned when their children develop preauricular or cervical skin tags. Gross[1] and Lederer,[2,3] authors of vast clinical experience, recommend sharp excision for those lesions large enough to warrant treatment. Many physicians, however, still resort to the expedient of ligating the pedicle, and await the subsequent necrosis and slough. This procedure is to be discouraged for the following reasons:

1. Danger of incomplete removal
2. Compromise of cosmetic effect
3. Existence of unexpected conditions

Incomplete removal

It is beyond the scope of this article to enter the controversy tracing the embryology of these structures. The available literature has been reviewed exhaustively by Miller.[4] The consensus is that these tags, in common with branchiogenic cysts, sinuses, and fistulae, are branchial remnants related to the first and second arches. Complete excision rests on understanding that certain elements may extend into the subcutaneous tissues. Preauricular tags are so common, they are seldom totaled in series of branchial arch abnormalities. Most are not associated with cartilage or sinus. Many do contain cartilaginous elements which project to varying depths beneath the skin. Cervical tags, often called cervical auricles, are far less common. They are more prone to deeper attachment in proximity with the sternocleidomastoid muscle and, rarely, the carotid sheath. Association with cervical branchiogenic fistulae has been reported.[5] The possibilities of infection, chronic drainage, and poor scar resulting from inadequate surgery are self-evident.

Case 1. R.B.M. 7373 USAF Hosp. 24976

A 5 day old white boy entered the hospital with a freely movable 3 cm., projection overlying the anterior border of the left sternocleidomastoid muscle, about 3 cm. from the suprasternal notch. It was excised under local anesthesia. The central core extended 5 mm. deep and appeared to be composed of cartilage. The pathologist's report stated ". . . irregular, ovoid firm tissue consisting of skin and subcutaneous tissue. No cartilage was seen on cut section." Figure 1,* adapted from Gross, illustrates this type of pedunculated lesion.

Case 2. M.R. 7373 USAF Hosp., 27316

Because his playmates teased him about his "wart," this 6 year old white boy was brought to the surgical clinic. He presented a 3 mm. projection along the anterior border of the lower third of the right sternocleidomastoid muscle. It did not move with swallowing or enlarge when a Valsalva maneuver was performed. At times it appeared more prominent and turgid. Under general endotracheal anesthesia, a transversely directed skin ellipse centering at the lesion was deepened to 4 cm. It followed a fibrous cord between the sternocleidomastoid and strap muscles, ending in irregular, firm tissue. Pathology was consistent with branchial arch rest. The report concluded, ". . . only unremarkable cartilage is abnormally seen. No cyst or sinus is present." Figure 2 shows the preoperative appearance.

Cosmetic result

Surgical excision enables the physician to strive directly for a planned hairline scar. For, although symptoms of foul taste and upward movement on deglutition have been recorded, most authors describe the obvious facial or cervical deformity as the presenting complaint and leading indication for surgery.[4]

Case 3. B.W. 7373 USAF Hosp., 26142

A 4 day old Negro girl had a stalked projection arising in the preauricular area 5 mm. cephalad and 8 mm. anterior to the right tragus. The lesion was sharply excised. Presence of carti-

Formerly Captain, USAF, MC



FIG. 1

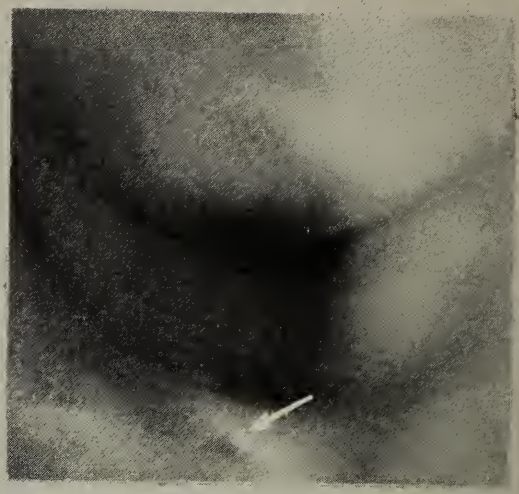


FIG. 2



FIG. 3

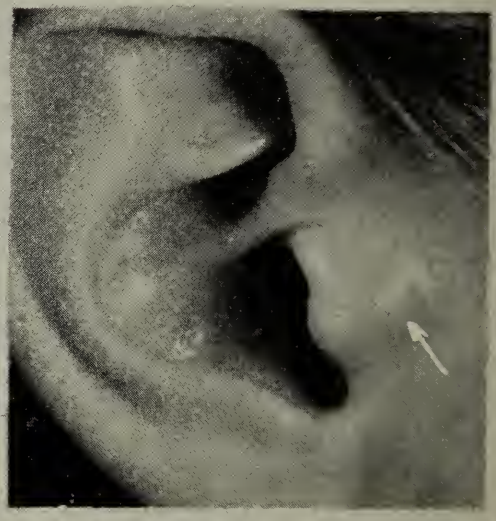


FIG. 4



FIG. 5



FIG. 6

lage jutting 5 mm. deep was confirmed by the pathologist. Figure 3,* adapted from Gross[1] demonstrates this type of anomaly.

Case 4. L.T.S. 7373 USAF Hosp., 21260-OP

A 25 year old white woman had had a preauricular tag ligated during her neonatal period. Figure 4 demonstrates the unfavorable cosmetic appearance. There is a prominent, irregular, cartilaginous residual beneath the wide cicatrix.

Unexpected conditions

The diagnosis of branchial arch remnant is made by recognizing the gross lesion. There are very few conditions to consider in the differential diagnosis. An occasional surprise diagnosis may be made by the pathologist.

Case 5. R.J.P. 7373 USAF Hosp., 28960-OP

An 11 year old white boy presented a conspicuous 4 mm. projection just anterior to his right tragus, present since birth. It was elliptically excised under local anesthesia. The pathology report returned the diagnosis of "Hair follicle nevus." Figure 6 is a preoperative view of this case. Note the similarity to the branchiogenic remnant of Figure 5.

It is agreed that nevi should not be ligated. Beven[6] states that he has seen a number of carcinomata which have been primary in branchial cleft cysts or cell rests. He presents two case histories. Roeder[7] also reports a case of malignant degeneration of a branchial remnant with survival 5 years after a radical neck dissection. Fried[8] presents two cases of sternoclavicular branchioma which he believed arose in embryonic rests. These involved the brachial plexus, producing pain and finally death. One is not startled to discover rare reports of malignant change in branchial remnants. Primary branchiogenic carcinoma is a recognized though heatedly debated entity.[9] The proportionate risk of malignancy arising in preauricular or cervical cutaneous appendages is too remote to be considered a primary indication for surgery.

Conclusion

Surgical exision is the only treatment recommended for conspicuous preauricular and cervical cutaneous appendages.

Summary

1. The branchiogenic origin of commonly observed preauricular and cervical cutaneous appendages is presented.

2. Surgical excision as the method of treatment for conspicuous anomalies is supported.

3. Illustrative cases are presented.

**Figures 1 and 3 reproduced from Gross[1] with permission of author and publisher.*

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The art of conversation is to be prompt without being stubborn; to refute without argument, and to clothe great matters in a motley garb. — *Disraeli*

Evaluation of a Rapid Method For Blood Glucose Determination*

Howard S. Traisman, M. D., and Alvah L. Newcomb, M.D.,* *Chicago*

Lipscomb and associates[1] reported a rapid method for the determination of blood glucose utilizing a paper impregnated with the glucose oxidase enzyme. In 218 instances we have used this test paper and compared the reading with simultaneously drawn "true" blood glucose levels in patients with juvenile diabetes mellitus. Our results are herein reported.

Methods

The test filter paper† is impregnated with the catalyzing enzyme glucose oxidase and a color indicator. It is packaged in tape form similar to that of Tes-Tape.® There are about 50 tests per dispenser. The test is specific for glucose, as other reducing substances will not react with the tape. The manufacturer's directions for use are as follows:

"1. Withdraw approximately 1½ inches of tape from dispenser by pulling down.
2. Tear tape by pulling up against cutting edge.
3. Dip tip of tape in blood specimen or collect a drop or two of blood on end of tape. The blood may be fresh finger-tip blood, fresh drawn venous blood, or heparinized, oxalated or citrated blood. The blood specimen should not contain fluoride.
4. Gently brush excess blood off on to tissue paper.
5. Wait three (3) minutes and compare wet portion with color chart by placing the tape on white area immediately below the color chart."

A color chart corresponding to blood glucose readings of 50, 125, 250, and 350 mg. per 100 ml. is used.

Blood glucose readings were made with the test filter paper utilizing one drop of venous or finger-tip blood. Various house staff members were instructed in the use of the test paper and recorded their readings. At the same time "true" blood sugar was being determined on venous or finger blood by the Somogyi-Nelson method (normal 60-95 mg. per 100 ml.)[2]. The determinations were made by two or more full-time technicians in the biochemistry laboratories from whence this paper originates. No attempt was made to read the tape between the standard colors that correspond to 50, 125, 250, and 350 mg. per 100 ml., respectively.

Results

The blood test paper utilizes a color range from 50 to 350 mg. per 100 ml. There is no change in color if the blood glucose is below 50 and a slight increase in color if the blood glucose is above 350 mg. per 100 ml. It is our clinical experience, as well as that of the house staff, even if unfamiliar with the paper, that one can rapidly determine if the patient's blood glucose level is low or elevated. However, it is in the middle ranges where the greatest error appears to exist. Repeated use of the tape allows one to make more accurate readings in the middle ranges of the color scale at 125 and 250 mg. per 100 ml. Table 1 is a summary of the statistical analysis, comparing the blood test paper to the

*From The Children's Memorial Hospital and Otho S. A. Sprague Memorial Laboratory; department of pediatrics, Northwestern University Medical School; and Evanston Hospital Association.

†*Kindly supplied by Dr. W. R. Kirtley, Eli Lilly & Company, Indianapolis. This test filter paper is available only on an experimental basis.*

determination of blood glucose by the Somogyi-Nelson method. Since one variable (blood test paper) is not continuous, but discrete, correlation analysis is not quite adequate, especially where as few as four color readings are included. It is because of this that the coefficient of correlation tends to be somewhat lower.

TABLE 1. Statistical Analysis of Efficiency of Blood Test Paper Compared to Somogyi-Nelson Method

	Somogyi-Nelson	Blood Tape
No. of Observations	218	218
Median	100	125
Class 1	69	50
Class 2	116	125
Class 3	244	250
Class 4	416	350
Mean & Standard Deviation	155.34 ± 86	120.99 ± 77
Class 1	80.37 ± 53.5	50
Class 2	155.11 ± 108.7	125
Class 3	308.00 ± 151.1	250
Class 4	416.08 ± 79.6	350

There does not appear to be good correlation between the two variables. Significant errors exist in reading the colors of the tape into corresponding quantitative values. It appears that one person varies in his reading ability from time to time; but more important, several persons with differing abilities to interpret the colors have participated in this study. Also, some errors in reading and in the tape itself are suggested by the misplacement of the two extremely high blood glucose values of 716 and 818 mg. per 100 ml. The results are less accurate because only four tape values are used. The results are also affected by the extreme values and skewness* of the data.

Due to these two factors, the dispersion measures (standard deviation and standard error) as well as the mean are not entirely satisfactory measures in the present case. However, even with these reservations, it is seen that the average blood glucose value (arithmetic mean) is significantly higher when measured by the Somogyi-Nelson method than when measured by the blood tape. This fact appears to be explained mainly by the insensitiveness of the tape in the lowest and highest ranges.

A better measure of the accuracy of the tape-measurements is suggested in Table 1 by using medians instead of mean values. This table suggests that the tape readings tend to be too high in the middle ranges and too low in both the lower and the upper extremes. This finding agrees with those of others.[1] Our study and Lipscomb's seem to suggest that the tape-color values should be adjusted in such a way that there would be a better correlation. The adjustment factor in this case is best suggested by the median values for blood glucose as compared to the blood tape values. Perhaps the blood tape values of 50 should read 70, 125 should read 115, 250 should read 245, and 350 should read 400.

However, in order to determine these adjusted values, further studies would be required wherein the variations due to reading abilities have been kept at a minimum.

Discussion

Experience with the use of filter test paper impregnated with glucose oxidase enzyme for the determination of blood and urine glucose has been reported by others[1,3,4]. The reader is referred to these articles for an explanation of the biochemical reactions involved. Lipscomb et al.[1], after analyzing 177 observations with this blood test tape, are of the opinion that it is a satisfactory method of determining quantitative blood glucose levels.

Although there is not a good statistical correlation in our study, the tape has certain definite clinical advantages. The test filter paper has its greatest value in the hospital emergency room as a rapid method of differentiating hypoglycemia from diabetic coma. We have used this tape in following the blood glucose levels of the infant of the diabetic mother. This is especially valuable where such an infant is tending toward hypoglycemia. It must be acknowledged that the more experience an observer has with this tape, the more valid the readings. If this paper is to

(continued on page 92)

**Frequency distribution bunched together at one side of the average and tailing out on the other side.*

The VIEW BOX

Franz Gampl, M.D., *Chicago*

A 13 month old Negro boy was hospitalized after five days of fever, chills, and a cough. The temperature was 100.8 F.; the pulse, 120/minute; the respiratory rate, 40/minute. The skin and mucous membranes were not cyanotic. The mucosa of the nose and pharynx were injected. Moist rales were heard over both lung bases. The physical examination was otherwise unremarkable.

A chest radiograph was ordered.

What is your diagnosis?

1) Left lower lobe pneumonia
2) Obstructive emphysema of the left upper lobe
3) Pneumothorax
4) Minimal atelectasis of the right lung

(*Continued on page 95*)

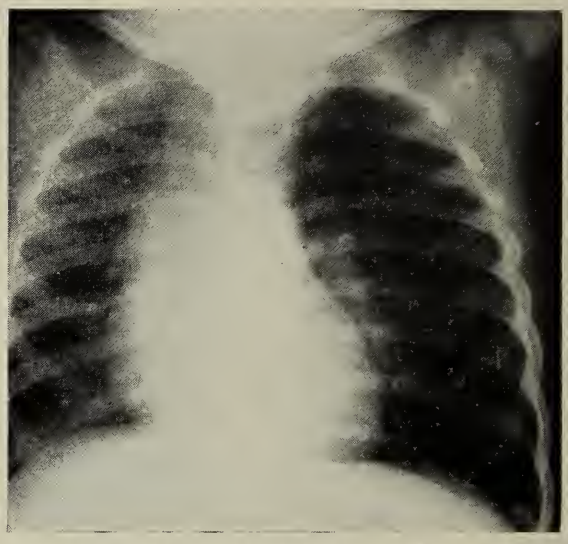


Figure 1. Chest roentgenogram taken on admission to hospital.

From the radiology department, Cook County Hospital.

Evaluation— Traisman *(continued from page 91)*

have a more reliable application, the color scale should be expanded to include more colors, or the median values should be adjusted as noted in table 1.

Summary

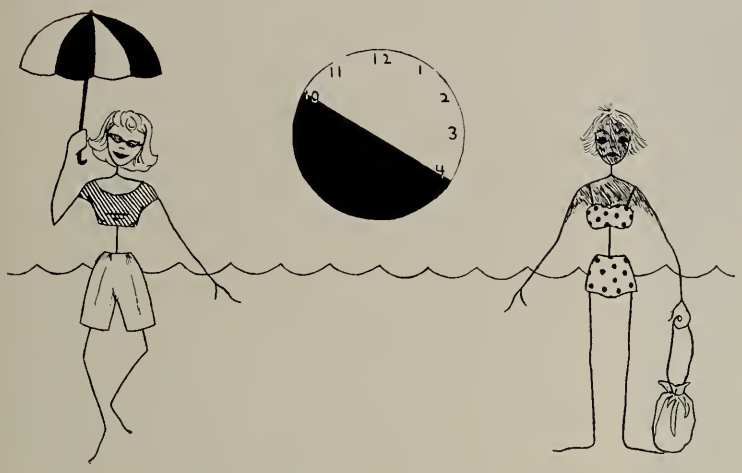
A statistical analysis of blood glucose readings determined simultaneously by the Somogyi-Nelson method and by a new enzyme-impregnated filter paper fails to show a good correlation. However, there are certain valuable clinical uses of this test paper. Suggestions for increasing the reliability of the readings have been advanced.

The authors wish to thank the house staff of the Children's Memorial Hospital and Evanston Hospital for performing the readings, and Dr. Boris Parl, who analyzed and reviewed the statistics.

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MEDICINE IN THE OUT-OF-DOORS



Sun and Skin

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Princeton

WE ARE LITERALLY children of the sun. The earth, born of the sun and under its constant influence these billions of years, is so modified, and all life that ever existed demonstrates this close bond. So man, a very recent newcomer to this globe—less than a million years ago, which is barely a wink of the eye in cosmic time—has within him the ancient longing for the life-giving rays. All aboriginal peoples and past civilizations had the utmost reverence for the sun and helioworship was a dynamic force in every culture. The contemporary American hopes for the image of an Athenian statue resplendent in bronze.

There are definite inherent hazards for the dreamer of this image, especially if the paleface desires to radically alter his complexion in several days of a two-week vacation during midsummer. Most changes in nature occur in slow rhythmic cycles, and it is best not to violate this rule in relation to the skin. Each summer doctors are beseeched to ease the discomfort of bodies racked by fever, headache, and more than 50 per cent lobster red. The typical explanation by the patient is that he only sunned himself for a couple of hours. Acutally, he did what only mad dogs and Englishmen do—venture forth in the midday sun for many hours.

Overexposure to sun, especially too much in a relatively short time, will produce damaging effects. The first and striking feature upon the skin is the intensity of erythema ranging from a faint blush to marked redness. Most of these are first degree burns no different from any other burns of this classification whether acquired by flash burns of other means. Burns of second degree intensity with blister formation are less common but more serious since the portals of entry lead to infection and its many complications. The treatment demands the same meticulous care as do all burns—cleanliness, antibiotics, and on occasion, intravenous fluids and steroids. The average case will usually respond at home to immersion in cold water, sedation, and the open dry method. The altered physiologic states resulting from this insult are many, and vary in intensity. Absorption of toxic skin-products and electrolyte imbalance are significant and made manifest by some or all of the following: fever, headache, malaise, nausea, vomiting, and constant pain in affected areas. Transient and rarely permanent neurological deficits in tactile perception and paraesthesias occur. The hair usually bleaches and becomes brittle. The lovely bronze maiden now has hair she "can't do anything with."

Inherited or predisposing skin conditions are aggravated by exposure to sunlight, but individuals with these have usually learned to protect themselves. Allergic reactions with urticaria are not uncommon. Systemic lupus erythematosus in a quiescent stage after solar exposure often makes a previously difficult diagnosis easy when the facial lesions appear. Most cases are diagnosed during the summer months.

Prolonged exposure to sunlight results in thickening and wrinkling of the skin—premature aging as seen in farmers, sailors, and others whose occupations take them for many hours out of doors daily. Wind action also contributes to these changes. These radiation and physical factors upon the unprotected skin result in many more malignancies as compared to the protected skin in the same individuals. Pterygium and other evidences of conjunctival irritations are common in these out-door persons for the same reasons.

Fair skinned, blue-eyed persons—blondes and redheads—are not, as a rule, as well adapted to withstand exposure to sun as are brunettes and dark-skinned people. The blondes only turn red and peel, whereas the redheads get redder and acquire more freckles. But are only brunettes and the dark-skinned among the chosen few? No, the majority can have the skin-deep symbol of virility and health if they understand that here, as in every other endeavor, there is no quick, straight road to success. And all is not damnation that radiates from the sun. Many maladies were alleviated or cured by gradual exposure before the advent of ultraviolet and infrared sources in hospitals where they are used today—bacterial and fungous infections, vitamin D deficiency in infants, to mention several.

If the status seeker must have his day, he should consider the following: In the northern tier of states during the months of May, June, and July, on a clear day, a 15-minute exposure between the hours of 10 a.m. and 4 p.m. is sufficient as the first dose on the unprotected skin. Because the rays must traverse a greater thickness of atmosphere before 10 a.m. or after 4 p.m., the skin-damaging portion of the spectrum is reduced, and slightly longer exposures can be safely tolerated. Increase the daily dosage no more than 5 to 10 minutes during the hours of 10 to 4. After four or five consecutive days of exposure, cover up for at least one day and begin anew at say a 45-minute exposure and continue. This procedure usually results in uniform tanning with minimal peeling. Withhold exposures to reddened skin or protect it.

Altitude, too, is important; burning occurs surprisingly fast in mountainous areas. Skiers get sunburned in January. A high overcast sky or even fog can be deceptive and inflict painful burns on the unsuspecting. The ultraviolet rays are still there. Reflections from beach or water are often forgotten until it is too late. Wearing sunglasses is always helpful when in direct sunlight. Burned and weather-beaten lips will be less so if given frequent applications of lipstick. The nose should be protected with a triangular papershield or adhesive tape, or if need be, by a mud pack. A red bugle and a summer cold are most incompatable. Those engaged in vigorous activity and prone to excessive perspiration will find a sweatband above the brows helpful. One salt tablet with each full glass of water is desireable. There is no way of preventing perspiration, all advertising to the contrary. Shave the axillary hair and bathe frequently.

The use of antimalarial or other drugs for tanning purposes are reserved for specific cases only. A number of sun-screening chemicals and skin-coatings are available. Many are effective within their prescribed limits, but often they lull one into believing in quick results and false security. It is better to follow the slow, steady course; even Icarus plummeted to doom for his enthusiasm of the sun.

No institution which does not continually test its ideals, techniques and measure of accomplishment can claim real vitality. — *Milton*

The View Box—diagnosis and discussion *(continued from page 92)*

The diagnosis is obstructive emphysema. These signs are pathognomonic: (1) widened intercostal spaces on the left, (2) somewhat low left hemi-diaphragm, (3) hyper-radiolucency of the left upper lung field, and (4) the diminution of the normal radiopacity in the upper parts of the mediastinum (herniation of the left upper lobe into the mediastinum) without complete disappearance of the normal lung markings in this area. These signs of increased intrathoracic pressure are absent in compensatory emphysema.

The increase in density behind the cardiac shadow suggested the presence of atelectasis and/or pneumonitis in the left lower lobe. This was confirmed clinically and radiographically.

Since the clinical findings permitted conservative management under antibiotic therapy, the patient was continued on this regimen. A chest radiograph obtained four days after admission showed the same findings.

At that time bronchoscopy showed considerable mucosal swelling. Viscid secretions were removed from the left side of the bronchial tree. Three hours later the breath sounds over the left upper lobe, which were previously decreased, were found normal. A follow-up radiograph obtained 20 hours after bronchoscopy showed normal aeration of the left upper lung field, and the herniation of the left upper lobe into the mediastinum was no longer present.

Obstructive emphysema is a common complication of upper respiratory infections and pneumonias in childhood.

Most of the check-valve mechanisms in the bronchial tree are due to mucous plugs and mucosal swelling, the presence of aspirated food and other foreign bodies must be considered; their removal will prevent serious complications. Obstructive emphysema may be lobar, segmental, or lobular depending upon the size of the obstructed bronchus. The lobular type is most often observed in bronchiolitis, both lungs appearing hyper-radiolucent and overdistended, and showing all the signs of obstructive impairment.

Cystic pulmonary emphysema is frequently encountered in postpneumonic pneumatoceles. They rarely require surgical intervention.

True congenital emphysema is rare and may be due to cartilage deficiency in the bronchial wall or to extrabronchial compression by cardiac enlargement or anomalous vascular structures.



Figure 2. Lateral view of the chest showing infiltration of the lower lube.

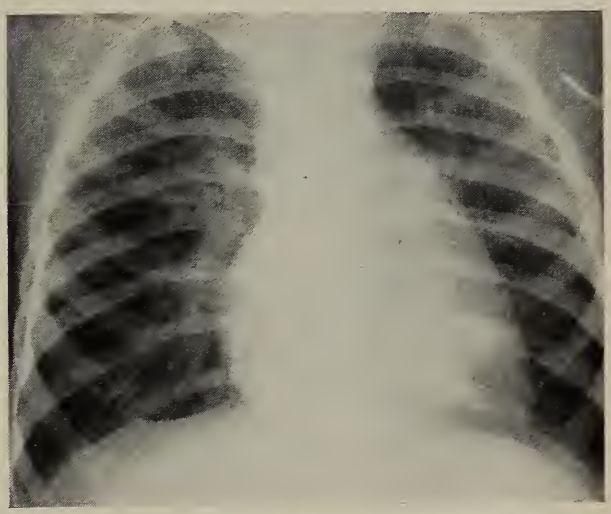


Figure 3. Control radiograph 20 hours after bronchoscopy.

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Chlordiazepoxide* in the Treatment Of Acute Alcoholism: A Preliminary Report

Herbert E. Karolus, M.D.,** *Dwight*

Alcohol is a drug which affects the cerebral cortex in a manner similar to that of ether. It depresses inhibitions to the extent that personality changes take place and behavior differs from the normal. Reasoning, judgment, memory, and control are interfered with, resulting in an escape from reality which apparently permits the alcohol user to live less painfully while under its influence.

The immediate hangover effects are usually accompanied by misery, guilt, remorse, tremors, depressions, and a promise never to repeat such a performance. We see the alcoholic not only as an acutely inebriated individual but one with a long history of acute binges superimposed on a chronic phase. It becomes necessary in therapy to alleviate the acute symptoms as rapidly as possible to make the patient amenable to treatment of his chronic alcoholism. The earlier the acute phase can be terminated and the symptoms alleviated the sooner the more important chronic phase can be dealt with. Easing the patient of his acute feelings promotes confidence in his doctor and paves the way for cooperation and acceptance of therapy.

The ideal treatment regimen should restore the inebriate to sobriety rapidly, forestall convulsions and prevent delirium tremens. It can be said that no one drug has the ability to produce these conditions by itself but that a combination of well selected drugs may be effective.

The tranquilizers are valuable adjuncts when combined with vitamins, a nourishing diet, intravenous fluids when indicated, rest, counseling and rehabilitation. However, as Hoff[1] has observed, these drugs are not without limitations. Thus, despite the beneficial effects of the phenothiazines in the management of agitation and restlessness, they have been of no value in the acute hallucinatory stage; the incidence of hallucinosis has not been significantly diminished nor the duration of delirium tremens shortened.[2] According to Fazekas et al.[3], the most significant advantage of the phenothiazines appears to be the

FIGURE 1. Severity of Withdrawal Symptoms. "Composite Number of Plus" in two 40-Patient Groups.



*Librium®, Hoffmann-La Roche Inc., Nutley, N. J.
**Medical Director, The Keeley Institute.

Table 1.—Sample Record of Patient on Chlordiazepoxide Therary

SYMPTOMS	1st Day				2nd Day				3rd Day				4th Day			
Time	8 AM	12 Noon	5 PM	7:30 PM	8 AM	12 Noon	5 PM	7:30 PM	8 AM	12 Noon	5 PM	7:30 PM	8 AM	12 Noon	5 PM	7:30 PM
Agitated		+++	+++	++	+											
Anxious		++	++	++	+	+	+	+								
Appetite		++	++	++	+											
Apprehensive		++	+	+	+	+	+	+								
Confused		++	+	+												
Convulsion																
Depressed					+	+	+	+	+							
Dizziness																
Euphoric		++	+													
Faint																
Flushed		++	+	+												
Giddiness		++	+	+												
Grandiose		++	++	++												
Hallucinations																
Headache												+				
Incoherent		+	+	+												
Incoordination		++	++	++	+	+	+	+								
Insomnia																
Intoxication		+++	++	++	+	+										
Memory lapses		++	++	++	+	+	+	+								
Nausea																
Obsessive		++	++	++												
Perspiring		++	++	+	+	+	+	+								
Pessimistic		+	+	+												
Phobia																
Remorse					++	+	+	+								
Restless		++	++	++	+	+	+	+								
Speech		+	+	+												
Stagger		+	+	+												
Stupor																
Tremor		+	+	+	++	++	+	+	+	+						

relief of the otherwise constantly persistent distressing insomnia without the production of disabling sedation, although in approximately 25 per cent of subjects with severe delirium tremens, large intravenous doses proved ineffective. Furthermore, on awakening, the tremor, anxiety, and hallucinosis may reappear.

A new psychotherapeutic drug, chloriazepoxide, has been used at the Keeley Institute for several months. Initially, it was cautiously added to the usual regimen until we were convinced it was effective. It is now being used as a replacement for some drugs, and the impressive results led to a controlled comparative study.

Procedure

Chlordiazeporide was administered to 40 patients and results of therapy compared with an additional 40 patients receiving other ataraxic or antitensive drugs. To determine whether the patient's symptoms had been relieved effectively and rapidly, the results were compared with the records covering a period of several years.

Symptoms the patient exhibited were observed, and each graded as follows: 3+, severe; 2+, moderate; and 1+, mild. The symptoms were carefully evaluated four times daily at 8 a.m., 12 noon, 5 p.m., and 7:30 p.m.

One 10 mg. chlordiazepoxide capsule was administered at 10 a.m. and 3 p.m. and 25 mg. was given at bedtime for a 3-day period. The 25 mg. dose was then reduced to one 10 mg. capsule and the medication continued for two additional days at which time all cases were manageable without further medication. In most cases medication may not have been necessary during the last two days but was continued as a precautionary measure.

Results

The composite number of plus (Fig. 1) indicates the severity of symptoms following the usual therapy with and without chlordiazepoxide. It will be noted that the lower figures represent

Table 2.—Sample Record of Patient on Routine Therapy Without Chlordiazepoxide

SYMPTOMS	1st Day				2nd Day				3rd Day				4th Day			
Time	8 AM	12 Noon	5 PM	7:30 PM	8 AM	12 Noon	5 PM	7:30 PM	8 AM	12 Noon	5 PM	7:30 PM	8 AM	12 Noon	5 PM	7:30 PM
Agitated		+++	+++	+++	++	++	+	+	+							
Anxious		++	++	++	++	++	+	+	+							
Appetite		++	++	++	++	+	+	+								
Apprehensive		++	++	++	++	+	+	+	+							
Confused		++	++	++	+											
Convulsion																
Depressed																
Dizziness																
Euphoric		++	++	+												
Faint																
Flushed		++	++	+												
Giddiness		++	++	+												
Grandiose		++	++	++	+	+										
Hallucinations																
Headache												+				
Incoherent		+	+	+												
Incoordination		++	++	++	++	++	++	++	+	+	+	+				
Insomnia					++				++				+			
Intoxication		+++	+++	++	+											
Memory lapses		++	++	++	++	+	+	+								
Nausea																
Obsessive		++	++	++	+											
Perspiring		++	++	++	+	+	+									
Pessimistic		+	+	+	+	+	+	+	+							
Phobia																
Remorse																
Restless		++	++	++	++	++	++	++	+	+	+	+				
Speech		+	+	+												
Stagger		+	+	+												
Stupor																
Tremor		+	+	+	++	++	++	++	+	+	+	+				

the more rapid subsidence of symptoms. With chlordiazepoxide agitation, anxiety, apprehension, grandiosity, incoherence, incoordination, confusion, memory lapses, obsessions, restlessness, tremors followed by remorse and depression were controlled more rapidly. No untoward effects were observed. The sample of patient records from each of the two treatment groups (Tables 1 and 2) reveal that the patients receiving chlordiazepoxide responded more quickly and that their after-effects or hangover from alcohol were relieved in a smoother manner.

Significantly, the usual three to five days necessary to restore the individual to some degree of normalcy was reduced to two or three days. The crucial third day when most instances of convulsions and delirium tremens had occurred in the past was uneventful.

Chlordiazepoxide has thus far all but eliminated the entire group of withdrawal symptoms and has made the patient amenable to treatment in a more efficient and prompt manner. Previously, patients frequently pleaded for more liquor while on withdrawal, and were usually a serious concern to the medical staff because of the special attention and medication required to control the patient's behavior at that critical time. Further, patients often abandoned treatment or sneaked off to get liquor in some devious manner to satisfy their craving. With chlordiazepoxide the patients usually became appreciative of therapy and, because of confidence gained were more receptive sooner. It became evident that the previous drugs used at the institute could be reduced in amount and that chlordiazepoxide provided the desired results formerly obtained with combined treatment.

Summary

Forty alcoholic patients were given chlordiazepoxide for the acute stage of withdrawal from alcohol and the results compared with another group of 40 patients receiving other tranquilizing drugs.

With chlordiazepoxide withdrawal symptoms were all but eliminated within two to three days as compared with the usual three to five days required for improvement. Furthermore, the critical third day associated with withdrawal therapy was without incident; none of the patients experienced convulsions nor delirium tremens.

From continuing experience, there is every indication that chlordiazepoxide is the therapy of choice for the alcoholic, and that it may replace entirely our present methods of therapy.

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Joint Meeting
of the

ISMS
Nutrition Committee

Illinois
Nutrition Committee

will present the 5 P's

***P**arents*
***P**upils*
***P**hysicians*
***P**lanners*
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in promoting the School Lunch Programs

Northern Illinois University, DeKalb, October 7, 1961

EDITORIALS

Today's crisis in medical education

Today's recruitment and selection of medical students presents one of the most important responsibilities and problems facing medical education now.

There is need for expansion in our *system* of medical education. By 1975, to maintain the present desirable ratio of physicians to population, 3,500 more medical students must be graduated each year. To compensate for attrition between admission and graduation, approximately 4,000 first year places must be provided by 1970.

In the face of this gigantic undertaking is the disturbing fact that for the third successive year the number of applicants for the existing places in medical schools has *decreased*. There is also some evidence that the quality of applicants has decreased. In 1950 40 per cent of applicants had A grades; now only 17 per cent have such averages. Academic attrition in the first year has also increased from 3 to 5 per cent.

Medicine is now competing with other professions, with new fields arising out of advances in science and technology and academic careers, and with other sciences for selection by top-ranking college students. These other fields now provide the prestige, intellectual satisfactions, and financial rewards comparable to those offered by medicine. The long, costly period now required for medical education may also be a factor now in deterring young people from the selection of medicine as a career.

There are other problems facing medical education. For example: Are sufficient efforts being made to attract and train basic medical scientists? Can the inordinate length of time before a student qualifies for practice be justified educationally and economically? Are the exceptionally talented premedical and medical students being meaningfully challenged? Is there sufficient cooperation, correlation, and integration between the departments within a medical school so that a basic core of knowledge can be presented for conceptual learning by the students?

We tried to design the new Northwestern program to help solve all of these problems. By decreasing the time in school from eight years to six years, we feel it will help make a career in medicine more attractive and will offer encouragement to the prospective student and so help increase enrollment.

The improved teaching techniques will increase the quality of education in health fields and so increase the quality of physicians.

Richard H. Young, M.D.

Benevolence committee

When you pay your dues, you contribute to the Benevolence Fund. Apparently this twenty year old committee remains unknown to many members of the Illinois State Medical Society. Its duties and functions are outlined in the Constitution and Bylaws; articles have appeared from time to time in the ILLINOIS MEDICAL JOURNAL; the Woman's Auxiliary has made contributions to the fund one of its main activities throughout all these years.

Eventually the Benevolence Committee hopes that the income from investments will carry the pay load to recipients. We are a long way from that goal. At the present time $140,000 in government bonds is held in the name of the committee; its routine expenses are paid out of

the general funds of the Society. Any check written on the Benevolence checking account is payable to a recipient of assistance.

Approximately $3,000 a month goes to needy physicians, their widows, or their dependent children. The maximum amount paid is $100 and the minimum about $40 each month. The names of the recipients are not given out except to the members of the committee. By special action on the part of the Council, emergency grants have been paid over the $100 maximum.

About 60 individuals receive checks each month, and about half this number are widows of former members. Many of the recipients write to acknowledge these checks, and their appreciation is expressed continuously and sincerely.

For some years $5 from each physician's annual dues was deposited to the account. Then this amount was cut to $2 per captia per annum. This allocation of $2 does not maintain the annual benefits paid to the recipients, but the very generous contributions from the Auxiliary each year, plus allocations of funds from the general account of the Society, have made it possible to operate without touching the $140,000 reserve. One downstate physician makes an annual Christmas contribution of $150. Many donations are received in memory of our outstanding physicians who have passed away during the past year.

Aid from the fund is not automatic, and we must depend upon the county medical society officers to give us information and to help us conduct the necessary investigations of prospective recipients. In addition to many elderly doctors or their widows, we have helped a young physician with tuberculosis, and we have helped the wife and children of a physician who is a patient in one of the state mental hospitals. Funds are not large, and this work should be aided and abetted throughout the state.

As the case load increases, it will be necessary to allocate more than $2 from each physician's dues to this activity of the state society. Members of the profession contribute through their dues structure, and so do members of the Auxiliary. The Auxiliary supplements its dues contribution by various fund raising activities at the county medical society level, and warrants the Society's sincere thanks and appreciation.

Contributions to the Benevolence Fund should be considered by members of the Society as a means of helping to provide for those less fortunate physicians or members of their families.

Frances C. Zimmer

Warning on repackaged drugs

Physicians' samples were in the news last month, principally through action taken by the FDA. Commissioner George P. Larrick warned druggists to destroy any drugs purchased from repackers of physicians' samples. He said a serious error had been found during the inspection of Nathan H. Baier, large drug repacker located at Shiller Park, Ill. Among the repackaged drugs at this establishment FDA inspectors found bottles containing "Tofranil," a potent drug for treating mental depression, labeled as "Donnazyme," a preparation for mild gastrointestinal conditions, and also as "Albee With Vitamin C," a vitamin product that is sold without prescription.

The estimated retail value of stocks of physicians' samples at the Baier establishment was in excess of $50,000. The samples were obtained from physicians by circularizing a mailing card reading as follows:

> "Dear Doctor:
> Don't Throw Away Your Surplus Drugs or Samples.
> I Will Buy Them From You.
> I Pay A Fair, Honest Price.
> Please Write or Phone."

The Chicago seizure was the fourth such action in a week. The following letter was found in the files of another repacker:

> "Dear Doctor: During the past several months you have undoubtedly accumulated a great deal of surplus physicians' samples. We are certain that you will appreciate an opportunity to exchange this surplus collection for your everyday office necessities. . . . The complete range of items we have available are listed on the enclosed sheet. They are not for sale but are given to you in exchange for your surplus samples. . . This type of arrangement is commonplace practice in many localities throughout the country. . ."

The FDA said it has no evidence that physicians generally dispose of their samples im-

properly. The samples are not illegal when properly labeled and used as such. Repackaging is dangerous because of the risk of mix-ups in the drugs. In addition, removing the words "Caution: Federal law prohibits dispensing without prescription" may cause a dangerous drug to be used without medical supervision.

Registry of Pathology

The American Registry of Pathology is a department of the Armed Forces Institute of Pathology and is under the sponsorship of the National Academy of Sciences-National Research Council. It is a cooperative enterprise in medical research and education between the Armed Forces Institute of Pathology and the civilian medical profession.

Its objective is the utilization of pathologic material in the acquisition and dissemination of knowledge in the field of pathology.

The American Registry of Pathology consists of 25 registries, each one dealing in a field of pathology with an individual registrar who is the chief of that section. Research is largely, but not exclusively, directed toward statistical analysis and clinical-pathologic correlation, particularly with reference to natural history of disease, including various therapeutic influences.

Education constitutes a large portion of the work of the registry. Each year approximately 15,000 well documented cases with pertinent material and data are registered (indexed and filed). At the end of December, 1960, 195,000 selected cases were available for study by qualified members of the staff. This material is selected from military and civilian sources. Cases from these sources pass through the Armed Forces Institute of Pathology Sections of the respective registrars, who select and register cases suitable for educational purposes.

The material in the American Registry of Pathology is used for the preparation of many scientific papers and special studies by members of the staff.

Through the administration of the American Registry of Pathology, various national societies sponsor fellowships in many fields at the Armed Forces Institute of Pathology.

A number of research projects and special studies, through the contribution of funds from various foundations and societies, are administered by the American Registry of Pathology.

Many atlases, syllabi, and manuals are prepared and sold by the American Registry of Pathology. Annually, approximately 30,000 publications are sold and distributed; the best known are the fascicles of the "Atlas of Tumor Pathology."

A large collection of teaching material is prepared, maintained, and loaned by the American Registry of Pathology. The average annual loan of study sets is 5,000 microscope slide sets and 500 clinical-pathologic conference sets.

The twenty-five individual registries of the American Registry of Pathology are listed on the Reference Page for this month.

Frank M. Townsend, Colonel, USAF, MC
The Director
Armed Forces Institute of Pathology

Reports on new drugs

Greiner[1] recently deplored the fact that the evaluation of new drugs by physicians is difficult and unsatisfactory. "Since the major part of clinical drug evaluation is in the hands of doctors with little scientific training, and since it seems likely to remain there, a plea is made for wide concern among doctors for the relatively simple methods of scientific study."

The editors of state and county medical society journals are confronted with this problem. They have the responsibility for publishing the results of research by physicians.

With experience, editors learn to detect authors with and without scientific training. We are suspicious also of therapeutic papers written by practicing physicians from other parts of the country, especially from those who are working and reporting on a wide variety of drugs. It is difficult to believe, for example, that one group of investigators have and treat so many hospitalized obese patients. They receive one drug this year and another the next, and their patients always lose weight. Meanwhile, they slip in 50 asthmatics and 65 hypertensives for treatment with other products. And the results are usually excellent.

We also receive articles written by local physicians but sent us directly from the pharmaceutical company. We assume that the clinical research was conducted by the author, but we have no way of knowing whether he was too busy

to evaluate the results and write the article, including the all-important summary. These articles are polished and well written but usually are rejected because we cannot be sure that the results and conclusions are those of the author.

We do not wish to discourage research from office and home laboratories. We want articles on controlled therapeutic trials and the use of new drugs, provided the work is honest and the conclusions are based on scientific knowledge, investigative intuition, and sound powers of observation. Most physicians are not trained in research and are unaware of controlled conditions and criteria of diagnosis. Not every study lends itself to the use of double blind methods of control, but these and other limitations should be recognized and mentioned in the discussion of methods of evaluation.

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1. *Greiner, Theodore. Why We Rarely Know about Drugs. J.A.M.A. 177:42 (July 8) 1961.*

Correspondence

Dear Dr. Van Dellen:

At the Lake Zurich Golf Club on the evening of June 3, 1961, at or about nine o'clock p.m., you read excerpts from letters received from several individuals who had written to ask your advice in your capacity as editor of the Chicago Tribune's "How to Keep Well" column. One of these letters was from a person who was concerned about the fact that one of his kidneys was lower than the other. It so happens that I am that person, and I am writing you on advice of counsel.

I might add that I am more than a little surprised that you would poke fun at my kidney or at an individual affected as I am. It seems to me to be a violation of the hypocrisy oath which all of you doctors are supposed to take — and to heed. It smells of trifling with your readers' kidneys.

I might also point out that it is not unusual, certainly not to the extent that fun should be poked at it, for one of two organs or parts of the human body to be lower than the other. For example, one of my shoulders is one and one half inches lower than the other, according to my tailor, and the same condition exists elsewhere in my anatomy, as it undoubtedly does in yours if you are the man I think you are. I am sure, moreover, that a somewhat similar condition exists among the fair ladies in our midst, and I will wager that in nine cases out of ten you will find one of their knees a little lower than the other. I challenge you to disprove this statement. And one of our most distinguished members has one eyebrow that's higher than the other, as I am sure all of you have noticed.

I also feel that, as a result of your comments, some people may think I am lacking in masculinity or something. Now I wouldn't like that to happen because somebody might get fooled.

So I think the only thing for you to do is to print a full retraction, probably in bold-faced type, in a forthcoming issue of your column. But don't head it "Try Standing on Your Head and Maybe It'll Go Back in Place."

I still would like to know what to do about my kidney, the one that is lower. As I have pointed out, it is not unusual for one kidney, or any other human organ which has a mate, to be higher or lower than its mate; within reason, that is. If you want scientific support for my assertion, see Sir William Osler's "The Principles and Practice of Medicine," page 937, or Palmer's "Putting the Tic in Chiropractic," page 111. Sir William, in his notable volume, cites several instances of adnormalities in dropped kidneys. In one case he describes, the right kidney had descended so far that it formed a bulge on the owner's thigh, halfway between the knee and the hip joint. In my own case, I have a large, bunion-like lump on my right foot. Do you suppose this could be my dropped kidney sticking out? If so, I'm glad it went down rather than up. Had it gone up, I might have choked on it. What do you advise?

Awaiting your reply, I am

Very truly yours,

Dear Dr. Van Dellen:

I want to say how much I am in sympathy with the editorial that you have in your June, 1961 issue having to do with the married intern. I think especially in your second paragraph the question as to where education ends and service begins is something which is more than an empty rhetorical question. The first objective should be to attain a thorough medical training, not to support a family. Or can you have your cake and eat it too?

I think the tendency to marry early has done another thing which is not remarked upon — it has tended to put interns and residents in hospitals where the pay is good and the teaching and opportunities for learning are poor. I don't have to spell out where those hospitals are, or what they are, or who runs them, because you know this as well as I do. This tendency then to marry early is one of the fetters by which the rising generation of medical men is being socialized. The hospitals I refer to are quasi-socialized institutions already.

At the end of the third paragraph you made a remark about the breadwinner not being on an eight-hour, five-day-a-week schedule. It seems to me they're on even a better schedule than that. I think that if you got down to bedrock and just found out how often these interns are in at night and whether they do, in fact, work more than eight hours, you might be surprised. After really serious scrutiny of this question, you might be ready to withdraw that remark at the end of the third paragraph.

The reason I write in this vein is that the medical profession, as I have watched it in the last twenty-five years, has done a lot of talking about socialization of medicine, but many medical men seem indifferent. Oh, they discuss it — they either discuss it in terms of the idea that the battle is already lost, or you cannot stay the tide of the inevitable, or they say we've got to compromise, and they render lip-service to the idea that they're fighting against socialized medicine, but they never, under any circumstances, take a positive stand. If it's a new state mental health thing, they want to be part of it; if it is a so-called welfare group run by the state, they want to be part of that; if the unions want a doctor, they want to get into that also; if it's a question of arranging a fee schedule so as to satisfy certain pressure groups in the community, I find that they are ready to negate surgical and medical training. By that I mean they are willing to take the position, in a fee schedule, that the hernia done by Joe Blow, who served an internship in some small, insignificant hospital somewhere, is quite as able to do the inguinal hernia, as far as the fee is concerned, as the fellow of the American College of Surgeons and the Diplomate of the American Board of Surgery.

They never say anything unpleasant to a patient about these matters that might interfere with their personal patient-doctor relationship, so that they back down about all these matters and do not stand up to be counted in favor of the system which they advocate. I had just about reached the point to suggest to our local medical society that we try to keep from office, in the local medical society, those whom we have reason to believe are not standing up to be counted about such matters as socialized medicine and other inroads into the practice of medicine by various pressure groups. In other words, if these men do not want to stand up and be counted, at least we can stand up and count them, and prevent them from taking a hand in running our affairs.

I was so much struck with the, to my mind, unusually correct attitude that I could not resist writing to you about it and congratulating you. Perhaps this outburst will tend to blunt your interest in writing further editorials. You may find this kind of stuff too hard to take.

With kindest personal regards.

Yours sincerely,
Adrien VerBrugghen, M.D.
Las Vegas, Nev.

Et tu Brute!

I thought that I had become used to American patients' knowing all about medicine; I am no longer surprised when they tell me that they have a postnasal drip, or that their white count is down, or that their blood-pressure is 170. But I did pause a minute when I asked a lady whether she had ever had any blood in her urine, and she replied, "Fifteen red cells per high-power field." *In England Now. Lancet. April 1, 1961.*

AT THE EDITOR'S DESK

Psychosis and amphetamine drugs

Dr. Milton A. Dushkin, medical director of the North Shore Hospital, warns that obese persons should be evaluated psychiatrically before reducing pills are prescribed for them. He reported several patients of his own and of others who developed psychosis following the use of amphetamine type drugs, including Preludin.

According to Dr. Dushkin, hunger-appeasing medicines "can irreparably affect the minds of emotionally high-strung persons." He stressed the point that excessive eating must in itself be considered a manifestation of an emotional disturbance. The drugs create a decrease in the usual defense mechnisms that people ordinarily excercise to control or allay inner anxieties. The breakdown in resistance leads in some instances to a complete emotional breakdown.

American Board of Microbiology

A new board to certify qualified scientists in public health and medical laboratory microbiology is now in operation. It is intended for persons widely trained in microbiology, including bacteriology, immunology, mycology, parasitology, serology, tissue culture, and virology. Candidates should hold acceptable doctoral degrees and have extensive experience.

Among the first nine to be certified were Dr. Howard J. Shaughnessy, chief, Division of Laboratories, Illinois Department of Public Health, and Dr. Gail M. Dack, director, Food Research Institute, University of Chicago.

Lengthening Arm of Federal Control

A recent court ruling lengthens the reach of the Federal Food, Drug, and Cosmetic Act. The Federal District Court ruled recently that a drug sold only in the state where it was manufactured but made from materials from outside the state, is subject to FDA control.

Pharmaceuticals

Librax is Roche Laboratories' new anticholinergic-sedative combination drug. Librium relieves anxiety and tension; Quarzan produces the antispasmodic and antisecretory effect. Roche claims that the new therapeutic agent is particularly useful for the treatment of peptic ulcer, irritable or spastic colon, gastritis, duodenitis, pylorospasm, and cardiospasm.

A new synthetic antibiotic, a derivative of Terramycin, has been developed by Chas. Pfizer & Co. It differs from Terramycin in possessing a 6-methylene substitute, an entirely new structural departure in tetracycline chemistry. The new antibiotic holds promise of high efficiency.

Isosorbide dinitrate (Isordil) had its day during the third annual meeting of the International College of Angiology. Four groups of investigators reported that the new coronary vasodilator reduced the frequency of angina attacks, and one went so far as to say it was superior to nitroglycerine. Its duration is two to three hours when used sublingually and four to six hours when swallowed.

A new package containing a 10 cc. vial of Atarax Parenteral Solution, each cc. containing 50 mg. of hydroxyzine hydrochloride, is being introduced by J. B. Roerig and Company. In addition, Roerig markets Atarax Parenteral Solution in 2 cc. ampules, containing 50 mg. per cc. and 10 cc. vials, containing 25 mg. per cc.

Old Age Insurance Plans on Increase

Life insurance plans for the aged and the handicapped are coming in strong.

United Equity Insurance Company of Chicago recently initiated a plan that offers straight life insurance coverage to those who have a history of heart or circulatory disease. It is written

directly from the firm's Chicago office, rather than through agents, and it requires no medical examination. Approval is based on a brief medical history supplied by the attending physician.

Metropolitan is now offering a new senior citizen's policy to those 65 or over which provides benefits for hospital confinement, as well as professional services. Benefits for surgical operations and for professional services of physicians and private nurses during confinement in a hospital or nursing home also are provided.

In 1956 Metropolitan began issuing hospital and surgical expense policies to persons in this age group. An improved coverage was made available on Jan. 1, 1961, to new applicants up to age 80, and at the same time the benefits were broadened and the premium was reduced.

The company pays a maximum of $15 a day for up to 180 days for hospital room and board under plan I and $25 up to 240 days under plan II. Convalescent care in a nursing home following a hospital confinement of at least seven days pays $7.50 per day under plan I and $12.50 per day under plan II for a maximum period of 30 days. It pays 80 per cent of any special hospital service charges above $50. The maximum for the most severe surgical operations is $250 under plan I and $500 under plan II.

Security Benefit Life Insurance Company will insure mentally ill, retarded, and cerebral palsied persons age 1 to 50, according to Joseph R. Gootar, sales director of the Chicago agency.

What's New?

Foil-Pac is a new advance in the packaging of surgical lubricating jelly. It contains 2.7 Gm. of sterile Surgilube in an easy-to-open, disposable foil package.

Electro-Medical Engineering Co. has announced a new line of pedal-driven exercisers. The Pedicisor provides controlled excercise analysis of patients undergoing examination or tests. It is a torque ergometer and is calibrated to measure work in foot pounds per revolution, foot pounds per second.

An electronic sphygmomanometer was introduced recently by Lafayette Radio Electronics Corporation. Pulse sounds from the brachial artery are picked up by a sensitive transducer in the pressurized cuff and converted into electrical impulses which are amplified and used to actuate an indicator lamp. The latter provides clear, easily recognizable indications of the systolic and diastolic pressure points. In other words, there is no need to use a stethoscope to determine blood pressure.

A portable, push-button air purifier has been developed by Engelhard Hanovia, Inc., for relieving allergy sufferers. It is reported to be 99.8 per cent effective in removing ragweed pollen from a room by electrostatic precipitation.

The Sierra Engineering Co. offers re-usable nylon bags in a variety of convenient sizes to permit safe, easy package sterilization of linens, dressings, and even sharp instruments. The nylon Autoclavable Bags are steam permeable and permit sterilization at temperatures up to 287 F. Once sealed and autoclaved the manufacturer claims that they are 100 per cent impermeable to bacteria and hence keep their contents sterile until needed.

Can a heart patient operate a mine motor, serve as an electrician's helper, or be a scale operator at a mine, taking into consideration his own safety and that of the other workers? An article in the May-June issue of *Rehabilitation Record* on the West Virginia Rehabilitation Center's cardiac work classification unit shows how the unit operates to supplement the physician's medical knowledge with information on actual job requirements and conditions, enabling him to prescribe vocational do's and don't's for cardiac employees.

Misleading Advertising Denied

The Federal Trade Commission has accused the manufacturers of Anacin, Bufferin, St. Joseph and Bayer Aspirin of misrepresenting the properties of their products. The charges were denied. According to the National Better Business Bureau, Inc., Service Bulletin, Plough, Inc., in denying the charges concerning St. Joseph Aspirin, contended that none of its advertisements challenged by the commission represents that the product provides relief of pain faster than any other analgesic preparation available to consumers, that St. Joseph Aspirin

disintegrates substantially faster than any other leading over-the-counter analgesic and is, therefore, "ready to go to work faster, which is the only claim made in ads representing that factor." Plough, Inc., also contends that its advertising does not state that St. Joseph Aspirin is faster than any other analgesic, but states in effect that none of the other leading analgesics is any faster-acting, a statement the firm submits is true.

Sterling Drug, Inc., denied any deception in its advertising and stated that its "advertisements of Bayer Aspirin and Bayer Aspirin for Children as bringing 'the fastest . . . relief you can get' were intended to and did represent that, notwithstanding the claims to the contrary of certain of respondent's competitors, no competitive analgesic preparation available to the general public provides faster relief of pain than respondent's products."

"Electric" Automobile

The electric automobile is coming back, according to *Science and Technology* published by the U.S. Department of Commerce. The belief is based on a new device — the fuel cell. The Army, Navy, and Air Force are doing considerable scientific research on this invention.

The battery has limited power, whereas the fuel cell continuously transforms a chemical reaction into electrical energy so long as a supply of "reactants" is fed into the system. In this respect it resembles familiar engines that operate as long as they have a supply of gasoline. The armed services are interested in the device as a means of propelling vehicles. Currently used power systems have reached maximum efficiency, and nuclear power is out-of-the-question because of the shielding needed and cost of the fuel. Small fuel-cell units have been operating continuously for more than a year, but additional engineering is necessary before they can be used in an automobile.

Statistical Corner

Approximately seven out of ten surgical procedures in this country are performed by physicians who specialize in surgery, according to the Health Information Foundation. Only two of the ten procedures are done by surgeons who are not Board certified to practice surgery nor members of the American College of Surgeons. Three of the ten are done by general practitioners or specialists in nonsurgical fields.

Household interviews conducted by HEW during the year ending June 30, 1959, uncovered the following estimations: Approximately 1,-161,000 civilians (noninstitutional) have hearing aids. This total represents one fifth of the people reported to have hearing impairments.

About 253,000 people used wheel chairs and 53 per cent of these were persons so disabled as to be confined to the house except in emergencies.

The survey showed also that there were 201,-000 persons with leg or foot braces and 494,000 with other types of braces. About 41 per cent of the leg and foot braces were worn by children under 15 years of age, usually because of poliomyelitis or congenital disorders.

In all there were 274, 000 people who reported absence of either arms or legs. Of these, 139,000 had artificial limbs; 94 per cent were males.

Correction

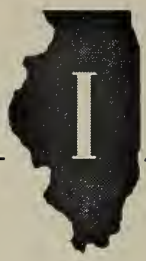
In the July Journal the following item, "Conflicting Voices," was incomplete. It is given below in its entirety.

A startling newspaper report on methotrexate in cancer chemotherapy quoted Surgeon General Luther Terry. It was in sharp contrast to the following Lederle news release that appeared a few days later: "Some of the interpretations of the Surgeon General's remarks have unfortunately given rise to overoptimism in some quarters. The two points most often misinterpreted are:

1. Methotrexate's ability to bring about five-year remissions: such results are limited to choriocarcinoma as reported recently — and only in some cases of this relatively rare form of cancer.
2. The newness of Methotrexate: It was discovered at Lederle Laboratories in 1948. . . ."

Our curiosity is aroused when two conflicting reports appear so close together. Was the Surgeon General trying to impress Congress with the advances made by the Institutes of Health and the need for continued appropiations? Was Lederle aware of this and prepared to soothe those who know what Methotrexate is capable of doing?

ANNOUNCEMENTS



Mental health and retardation Workshop proposed

Gov. Otto Kerner has invited representatives of 17 organizations actively interested in mental health and mental retardation to participate in a two-day workshop conference, September 8 and 9, at the Chicago office of the Illinois Department of Public Welfare. Dr. Francis J. Gerty, welfare director, will be the chairman of the conference. One of the specific problems for discussion will be the payment program for care and maintenance of patients in state mental institutions.

Under the present program the Welfare Department's Reimbursement Service protects the estates of patients and collects payment for state services; however, the governor expressed the desire of "establishing a patient care pay plan which is fair and equitable to both the patients and their families and consistent with sound principles of state government."

It is hoped that the meeting will result in a published report of mutually agreeable recommendations for the philosophy and administration of the program. Thus, proper legislation may be introduced during the 73rd General Assembly to implement, if necessary, the decisions resulting from the proposed conference.

AHA's annual meeting

The American Hospital Association's annual meeting September 25-28 in the Convention Hall at Atlantic City, N.J. will have "Hospitals in a Changing America" as its theme. The assembly will include over 40 program sessions and nearly 500 exhibits on all aspects of hospital operation.

During the meeting James E. Stuart of Chicago, president of the Blue Cross Association, will receive the Justin Ford Kimball award for outstanding contributions to the concept of voluntary nonprofit prepayment of health care. Dr. Jack Masur, director of the Clinical Center, National Institutes of Health, Bethesda, Md., will be inducted as president before the House of Delegates on September 27. He will succeed Frank S. Groner, administrator of Baptist Memorial Hospital, Memphis.

Meeting in conjunction with the AHA will be the American Association of Hospital Consultants, September 23; the American Association for Hospital Planning, September 23-24; the American College of Hospital Administrators, September 23-25, and the American Association of Nurse Anesthetists, September 25-28.

Pediatricians to meet in Chicago

The American Academy of Pediatrics has planned its annual meeting for September 30 through October 5 at the Palmer House in Chicago. Symposiums at the general sessions will be on "Chromosomes of Man," "Protein Nutrition," "The Prophylaxis of Allergic Disease in Infancy," "The Battered Child Syndrome," "Parasite or Invader—Host Factors in Infections," "Adoptions," and "The Advantages and Hazards of Live Measles and Polio Vaccine." The Mead Johnson and Borden Awards will also be presented at these sessions. Nine motion pictures are scheduled from October 2 through 4.

Section meetings will be devoted to allergy, cardiology, child development, diseases of the chest, military pediatrics, and surgery. Two-day seminars will be on September 30 and October 1

and half-day round tables from October 2 to 4.

The Bret Ratner Memorial Lecture will be presented by Dr. Jerome Glaser, Rochester, N.Y., on "Prophylaxis of Allergic Disease in Infancy."

A banquet with music and floor show will be held on October 4.

For further information contact the Academy Office, 1801 Hinman Ave., Evanston.

Fracture association meeting

The American Fracture Association is to have its annual meeting September 16-23 at the Shoreham Hotel in Washington, D.C. Part of the program will be a tuition-free postgraduate course on orthopedic surgery and fractures (worth 6 hours credit) on Sunday, September 17 at the Georgetown University Medical Center.

Milwaukee county society Conference

"All that's New in Medicine" will be the subject of the first annual Milwaukee Medical Conference October 19-20, sponsored by the Milwaukee County Medical Society, at Milwaukee County Hospital. All physicians and their wives are invited to attend the meeting and social events.

It will be part of week-long postgraduate medical activity incorporating Wisconsin specialty societies, Marquette University School of Medicine, University of Wisconsin Medical School, medical alumni groups, and hospitals in the area.

Over 20 speakers from the nation's leading medical centers will participate in the discussions, which include internal medicine in clinical pathologic physiology of disease, presentations on radiology, and "What's New" in various fields of medicine.

Requests for further information should go to Wilson Weisel, M.D., Chairman, Milwaukee Medical Conference Planning Committee, 756 N. Milwaukee St., Milwaukee 2.

Cancer society's scientific Session in New York

"The Physician and the Total Care of the Cancer Patient" will be the topic of the Scientific Session of the American Cancer Society's annual meeting October 23-24 in New York City's Biltmore Hotel.

Speakers from Chicago will be Miss Edna Nicholson, Institute of Medicine, "The Role of Supporting Services in Caring for the Cancer Patient;" Dr. Sammuel G. Taylor, III, Presbyterian-St. Luke's Hospital, "Internist's Opinion;" The Rev. Dr. Granger E. Westberg, University of Chicago, "Pastor's Opinion;" and Dr. Donald Oken, Michael Reese Hospital and Medical Center, "Psychiatrist's Opinion."

For more complete information contact the Professional Education Section, American Cancer Society, 521 W. 57th St., New York 19.

Mississippi Valley Society Dissolved

The Mississippi Valley Medical Society was dissolved at a special meeting of its members in Quincy in June. The society, a not-for-profit, federal income tax-exempt, educational organization, had been concerned with the postgraduate medical education of general practitioners in the upper and central Mississippi Valley states. However, since the American Academy of General Practice has largely taken over this field, it was felt advisable to dissolve, with all cash on hand, money in the Endowment Fund, and all equipment being given to the Society for Academic Achievement.

The *Mississippi Valley Medical Journal,* official publication of the MVMS, ceased publication in July and was incorporated with *Clinical Medicine.*

Pay-as-you-learn TV

Teleglobe Pay-TV System, Inc., New York has formed the Medical TV Network, Inc. to bring to physicians postgraduate refresher courses, information regarding progress in medical techniques, and news of the latest drugs. An electronic device called "Medicoder" will insure closed circuit viewing of specialists giving live and recorded visually-illustrated lectures and demonstrations. Physician-subscribers will be charged a small monthly fee to cover the cost of the special portable TV set, its servicing, and the production of the programs.

Broadcasts are scheduled to begin later in the year in New York City and then move into other

major markets, using early morning hours such as 7:30 to 8:00 or 8:00 to 8:30 when local TV is not in use. The programs will be repeated on the week ends.

A medical advisory board of physicians and surgeons will study programming to be used and serve as consultants on all aspects of the service. There will be no commercials, but pharmaceutical firms will report on their research programs, new drugs, and developments in therapy.

Public health awards founded

The American Public Health Association has announced the establishment of the annual Bronfman Prizes for Public Health Achievement by a grant from the Samuel Bronfman Foundation, Inc. The awards will honor outstanding current creative work leading directly to improved health for large numbers of people and will be given for work of particular effectiveness in applying newer scientific knowledge to community health rather than for achievement in basic or laboratory research.

One to three prizes of $5,000 in cash and a commemorative symbol will be awarded annually, depending on availability of suitable candidates. First awards will be announced and presented during the association's annual meeting in Detroit in November.

With the establishment of the Bronfman Prizes, the Association this year continues to grant only one other award—the annual Sedgwick Memorial Medal in recognition of long and distinguished careers in public health.

In honoring application rather than discovery of new scientific knowledge with the Bronfman Prizes, the foundation and the association hope to increase understanding and appreciation of public health practice.

PG course in gastroenterology

The American College of Gastroenterology's annual course in postgraduate gastroenterology will be given at the Sheraton-Cleveland Hotel in Cleveland, October 26-29. The course will cover the advances in diagnosis and treatment of gastrointestinal diseases, and faculty for it will be drawn from the medical schools in and around Cleveland. There will be comprehensive discussions, an "x-ray classroom" of instructional demonstrations, and a class in cinegastrophotography. One session will be held at the Cleveland Clinic and one at the Cleveland Academy of Medicine.

For futher information write the American College of Gastroenterology, 33 W. 60th St., New York 23.

Urological association's essay prize

The American Urological Association is offering an annual award of $1,000 (first prize $500, second $300, and third $200) for essays on the result of some clinical or laboratory research in urology. Competition is limited to urologists who have been graduated not more than ten years and to hospital interns and residents doing clinical or laboratory research work in urology. Animal research is not necessary.

For more information write the Executive Secretary, William P. Didusch, 1120 N. Charles St., Baltimore 1, Md. Essays must be received before November 15, 1961.

CME becomes a university

The College of Medical Evangelists, the 56-year-old medical education center in Loma Linda—Los Angeles, became Loma Linda University July 1. Two liberal arts colleges, La Sierra College in Arlington and Pacific Union College in Angwin, are associating with the university organization.

Birth rate declines

The Public Health Service has reported that births in this country are estimated to have exceeded deaths in 1960 by 2,593,000. This represented a rate of natural increase of 14.4 per thousand population, down slightly from the rate of 14.9 in 1959.

The Service's National Office of Vital Statistics found that the birth rate per 1,000 population decreased in 1960, compared with 1959, by 2.1. An estimated 4,247,000 babies were registered during 1960, about 2,000 fewer than in 1959, and an estimated total of 4,295,000 babies, including those who had not been registered, were born in 1960.

Films

"The Next Step," a 30-minute medical motion picture reporting on a successful community saturation program with the Sabin oral polio vaccine, presents detailed information on the development, manufacture, testing, immunization properties, and methods for using the new vaccine, which is pending licensure for general use in the United States.

The film urges that when the Sabin vaccine is licensed, it be used in well-coordinated community immunization programs under the leadership of the medical profession.

Just such a program as advanced by the Dauphin County Medical Society in Harrisburg, Pa. is depicted in "The Next Step." Sequences show how Dr. Thomas F. Fletcher, Jr., chairman of the society's subcommittee on child health, conceived the program, interested his medical colleagues, and rallied some 100,000 persons behind a community saturation effort this past spring.

Scenes from a similar, but smaller clinical program in the Greater Boston area are also incorporated in the film presentation. The black-and-white film was produced for the Pfizer Laboratories Medical Film Library by N. Weissman Productions, Inc. Technical assistance was provided by the U.S. Public Health Service and many of the physicians whose work is described in the motion picture. Versions of it will be available shortly to county medical societies, hospital staffs, public health groups, medical schools, and other related health units. It was premiered at the AMA meeting in June.

A new teaching film, "The Diagnosis of Viral Meningitis," covers clinical diagnosis and epidemiological considerations; the collecting and handling of specimens for the laboratory; definitive laboratory procedures for isolation and identification of etiologic agents; new and faster methods of laboratory diagnosis.

It was prepared by members of the staff of the University of Kansas Medical Center and of the Kansas City Field Station Unit of the U.S. Health Service. It is 16 mm., color, sound, and runs approximately 35 minutes. It may be borrowed free of charge, except for return postage and insurance, by writing the National Foundation, Department of Professional Education. At least three weeks' advance booking is requested.

Wayne State University College of Medicine, Detroit, is producing a physical diagnosis film series which can be used as a teaching clinic, basic science exercise, or as the story of a disease, sponsored by Ciba Pharmaceuticals, Inc. Six of the 16 mm. sound and color movies, based on a case bank of physical diagnostic signs—but not examination techniques, have been completed, and another is in the making. They are "Introduction to Speech Disorders," "Communicable Disease," "Gait and Musculo-Skeletal Disorders," "Disorders of Motility," "The Ear and Hearing," and "The Larynx."

The films, directed by Dr. Frederick J. Margolis, may be borrowed or purchased from the Audio-Visual Utilization Center, Wayne State University, Detroit.

The National Foundation has released a new teaching film, for physicians and nurses, "The Diagnosis of Hidden Congenital Anomalies." It was prepared by Virginia Apgar, M.D., director, division of congenital malformations, The National Foundation, and L. Stanley James, M. B., department of pediatrics, College of Physicians and Surgeons, Columbia University. The film demonstrates a simple method of examination, done in the first few minutes after birth, for the diagnosis of choanal atresia, laryngeal stenosis, tracheoesophageal fistula, intestinal obstruction, rectal atresia, cleft palate, and diaphragmatic hernia.

It may be obtained free of charge from the Department of Professional Education, The National Foundation, 800 Second Ave., New York 17. At least three weeks' advance booking is requested.

Smith Kline & French Laboratories has brought out its 1961 catalogue of 16 mm. sound motion pictures available on a free-loan basis. Included are "Psychiatric Nursing," one of four documentary films nominated for an Academy Award; three films from the new SK&F Teaching Film Series; the latest movie from the "March of Medicine" network TV series, "MD USA;" kinescopes of SK&F closed-circuit TV clinics; filmed reports by individual investigators, and special Film Center productions.

The booklet contains 31 films, 11 in color, with 16 available only to professional audiences and the remainder suitable for lay viewing. A description of each, with length of viewing time, is included. Copies of the new booklet are available from local representatives of SK&F or the Medical Film Center, 1500 Spring Garden St., Philadelphia.

"External Cardiac Massage," a film showing a recently developed technique for restarting hearts which have stopped beating—without opening the chest, was also released by SK&F Laboratories. The 21 minute, color movie is available on a free loan basis and was produced in cooperation with the technique's originators, all of the Johns Hopkins Medical Institutions.

"Hypoxia — Indications for Oxygen Therapy," a film surveying the causes and effects of hypoxia, has been completed by the Oxygen Therapy Department of Linde Company, Division of Union Carbide Corporation. Dr. Edwin R. Levine, director of inhalation therapy at Edgewater Hospital and assistant professor at Chicago Medical College, is technical director and narrator.

The 30 minute, 16 mm., sound and color movie, available on a free-loan basis, reviews the basic physiology of respiration and demonstrates clinical recognition of hypoxia's major types.

Featured is a photographic sequence of tissue hypoxia produced by coronary artery ligation in a dog's heart and its improvement by oxygen inhalation.

To obtain a print contact the nearest Linde oxygen therapy representative or Dept. HF, Linde Company, 270 Park Ave., New York 17. Adding an alternate showing date is advisable.

Clinics for crippled children

September 1 Chicago Heights (Cardiac), St. James Hospital
September 6 Carmi, Carmi Township Hospital
September 6 Carrollton, First Baptist Church
September 6 Hinsdale, Hinsdale Sanitarium
September 6 Rock Island (Cerebral Palsy), Foss Home, 3808 - 8th Avenue
September 7 Effiingham, St. Anthony Memorial Hospital
September 12 East St. Louis, St. Mary's Hospital
September 12 Peoria (a.m. - Cerebral Palsy), (p.m. - General), Children's Hospital
September 13 Champaign-Urbana, McKinley Hospital
September 13 Joliet, Silver Cross Hospital
September 14 Anna, County Hospital District
September 14 Sterling, Community General Hospital
September 14 Springfield, St. John's Hospital
September 19 Alton, Alton Memorial Hospital
September 20 Evergreen Park, Little Company of Mary Hospital
September 20 Jacksonville, Our Saviour's Hospital
September 21 Decatur, Decatur-Macon County Hospital
September 21 Elmhurst (Cardiac), Memorial Hospital of DuPage County
September 21 Rockford, Rockford Memorial Hospital
September 26 Peoria, Children's Hospital
September 27 Aurora, Copley Memorial Hospital
September 27 Centralia, St. Mary's Hospital
September 27 Springfield (Cerebral Palsy), Memorial Hospital
September 28 Effingham (Rheumatic Fever), St. Anthony Memorial Hospital
September 28 Sparta, Sparta Community Hospital

Correction

"A Case of Neuromyelitis Optica" by Homer B. Field, M.D., Blue Island, was presented at the Eye, Ear, Nose and Throat section meeting of the Society in May, 1960, not before the Section on Anesthesiology, as stated in the June, 1961 Journal, page 362.

The trouble with worrying so much about your "security" in the future is that you feel so insecure in the present. — *Harlan Miller*

NEWS of the STATE

County

Cook

Northwestern to expand research program

Clinical research at Northwestern University Medical School and Passavant Memorial Hospital is being expanded through a $2 million, 7-year program supported by the National Institutes of Health. The funds will be dispersed each year, beginning with a grant of $250,000 for 1961, and will increase each year until 1968.

Northwestern's research will be conducted at Passavant, where construction will begin September 1 on a 14-bed, self-contained research center on the third floor of the east pavilion to be completed in late December, when the program will start. In addition to the present metabolism unit, there will be two more laboratories, a patient physiological observation room, an external isotopic counting room, instrument room, and utility facilities.

Co-principal investigators will be Dr. Richard H. Young, dean of the medical school, and Dr. David P. Earle, professor of medicine at Northwestern. Dr. Francesco del Greco, director of the metabolism unit and associate in medicine, will be director of the entire research facility. Other personnel will include a chemist, three technicians, secretary, dietary staff of six, and a nursing staff of 18 for 24-hour service.

A supervisory committee of representatives of both the school and hospital will be responsible for general policy, the quality of medical care, and distribution of beds among the various research projects undertaken in the center.

The grant is one of 13 totalling $3,892,416 made by Surgeon General Luther L. Terry of the U.S. Public Health Service on recommendation of the National Health Council for new general clinical research centers in private institutions in 10 states and the District of Columbia. The program, begun in 1959 at the direction of the Senate Appropriations Committee, is aimed at enlargement and intensification of clinical research in a broad spectrum of diseases.

Dr. Falls honored

Dr. Frederick H. Falls, Oak Park, received the distinguished service award of the Illinois Interprofessional Council at its annual meeting for his devotion and contributions in the field of



Dr. Frederick H. Falls

medicine for the betterment and welfare of the people of the State.

Dr. Falls has been a teacher, a consultant, and an author as well as a practicing physician. He was professor of obstetrics and gynecology and

head of the department at the University of Illinois College of Medicine from 1926 to 1954 and is now emeritus professor. He had held a similar position at the University of Iowa five years before coming to Illinois. He was the founder of the Illinois Obstetrical and Gynecological Society.

He has held many positions including chairmanship of the Governor's Advisory Committee, State Department of Public Health, and Chairman of the Maternal Health Committee of the Illinois State Medical Society. He is president of the American Association of Maternal and Infant Health; and a fellow of the American Gynecological Society, American College of Obstetrics and Gynecology, American College of Surgeons, and the Illinois College of Surgeons.

Besides numerous papers, he has written two text books, "Obstetrics and Gynecologic Nursing" and "Obstetric Nursing." He also edited and published an atlas on Obstetrical and Gynecological Procedure.

New research buildings at Michael Reese

Michael Reese Hospital and Medical Center, an affiliate of the Jewish Federation of Metropolitan Chicago, has been given private gifts totaling $875,000 to help make possible the construction of two new research buildings. The two buildings, the $1,700,000 Alice and George



Drawing of Alice and George Dreyfus Laboratory

Dreyfus Laboratory and the $400,000 Laz Chapman Institute of Pathology, are part of the $16,000,000 expansion program.

A gift of $300,000 towards contruction of the laboratory has been made from the estate of the late Alice Levy Dreyfus by Mr. and Mrs. Samuel R. Rosenthal and son Martin, on behalf of the Dreyfus estate. Mr. Rosenthal, an attorney, is a partner in the firm of Sonnenschein, Lautmann, Levinson, Rieser, Carlin and Nath.

Other grants for the laboratory are $700,000 from the federal government and $75,000 from the Foundation for Cancer Research; and an additional $100,000 has been pledged by other friends of the hospital. This leaves a balance of $525,000 to be raised by the hospital.

The Laz Chapman Institute will be built in the memory of Laz Chapman, who was president of H. Kramer & Co. for 20 years and a board member of the Jewish Federation. Upon Chapman's death last year, his friends formed the Laz Chapman Memorial Foundation and have undertaken to raise $400,000 for construction of the Pathology Institute. Chapman's widow, Rose Kramer Chapman of Chicago, is honorary chairman of the Foundation.

The Dreyfus Laboratory will be built adjoining the Cummings Research Pavilion. Its six floors will house such research laboratories as the departments of hematologic research, cancer research, research in human reproduction, and gastro-intestinal research. The new building will replace facilities currently housed in the old Nelson Morris Research Institute Building.

The Laz Chapman Institute of Pathology will be a two-level building adjoining the new Dreyfus building. The basement level will include pathology department facilities, and the upper floor will house laboratories for research, tissue banks, and facilities for training students.

Groundbreaking for both buildings will take place in October.

New chronic disease hospital

The Chronic Disease Hospital, newest of the University of Chicago medical facilities, was dedicated July 12 "to the study and understanding of chronic disease, to its prevention, and to the amelioration of its ravages."

The National Institutes of Health have granted $452,416 for the initial phase of research, and the University has earmarked an additional $800,000 for specific research projects. These studies will be carried out on one of the three floors of the new 104-bed building. The federal grant, which is expected to be renewed, will permit the medical school to admit some research patients to the new hospital for intensive study.

Research will center on such chronic diseases as heart, cancer, psychiatric disorders, metabolic and genetic diseases, and changes attendant upon the aging processes.

A total of 20 full-time staff members of the university will be assigned to the program, including two dieticians, a social worker, five laboratory technicians, and a biometrician.

The three floors of the hospital are identical, built on what the architects call a "racetrack" plan. The common service quarters are in the middle, with the rooms radiating around them. There are examining and interviewing rooms on each floor, as well as a large central activity area that provides space for dining for ambulatory patients, occupational therapy, excercise, and visiting. Kitchens are arranged so that patients who are able can take their meals on trays from a cafeteria line to the central activity area.

All corridors are provided with hand-rails on both sides to assist infirm people in walking. The floors have treaded center paths with tile sides, so that the patients can have the security of a tread as well as a glazed surface for sliding a paralyzed or partially paralyzed leg. Patients returning for out-patient treatment can be brought directly into the hospital's lower level to its physical therapy facilities.

There is a direct connection to Billings Hospital on every floor to permit access to the operating rooms and other treatment centers of the main units.

The Chronic Disease Hospital has been built as a result of an affiliation agreement between the University of Chicago and the Home for Incurables which provided half of the $2,920,000 construction cost. The Home for Incurables has given its former site to the university and will use its $2 million endowment toward the program of care for the aged and for the chronically ill.

NU picks new program trainees

Northwestern University announced final selection of 25 exceptionally gifted high school graduates as 'pilot" enrolls in its revolutionary medical training program which shortens by two years the time necessary for the M.D. degree (The Journal, 117:372 (May) 1960).

At the same time the university disclosed plans for a $7.5 million building addition to the Medical School on the Chicago campus.

The wing will house expanded research and library facilities and provide space for new "unit laboratories" which are an integral part of the revised medical curriculum for all students, beginning in 1963.



New $7.5 million wing will adjoin the Ward Memorial Building (right) at Northwestern University Medical School. The 15-story building containing 92,000 square feet of space will increase the education and research plant by 50 per cent.

The new six-year program admits the 25 "charter" students to Northwestern's Medical School directly from high school.

They begin revised premedical studies this September in the College of Liberal Arts on the Evanston campus. After two years of work that stresses the basic sciences, the pilot group transfers in 1963 to the Medical School, joining the regular incoming class of approximately 100 others who have had the traditional three to four years' premedical education.

Thus, in six years, they will have achieved the professional degree. In eight years after high school graduation, they can earn the combined M.D.-Ph.D. degree.

Of the 25 picked as "pioneers" in the new program, four are women. They represent nine states, and all are 1961 high school graduates. Their medical training is expected to take place chiefly in the new research-laboratory wing, a 15-story structure to adjoin the east edge of the Ward and Morton buildings in the Northwestern

University Medical Center complex, Chicago. The land now is used as a parking lot. Construction probably will begin in the spring of 1962. Costs of the building and equipment are to be raised through private contributions.

Selection of the finalists was announced jointly by Dr. John A. D. Cooper, associate medical dean and director of the program, and C. William Reiley, Northwestern director of admissions.

The group averaged in the upper 2 per cent of their classes. They were in schools located in Illinois, Indiana, Wisconsin, Minnesota, Missouri, Ohio, Texas, Montana, and California.

Eleven were either valedictorians or salutatorians. All have participated heavily in a wide range of extracurricular activities in and out of school. They qualify for advanced work in chemistry, mathematics, and in one of the humanities on the basis of superior achievements in high school and in examinations.

In their opening two-year undergraduate period, they will devote about half their time to newly-developed courses in chemistry, physics, mathematics, and biology—arranged in coordinated, graduated sequence. Other courses of study will be in the arts, humanities, and behavioral sciences. Seminars in the arts and humanities are scheduled during the junior and senior years.

Planning of the integrated curriculum began in 1957 with a grant from the John and Mary Markle foundation.

During the first three years of operation, an initial grant of $257,000 from the Commonwealth Fund of New York will provide financial support for faculty members developing and teaching new courses necessary to the program.

The Commonwealth Fund also has pledged financial support for the proposed building. In addition, federal matching funds have been requested from the National Institutes of Health for construction of the research portion of the building. Several major philanthropic foundations will also be requested to pledge capital support for the educational portions of the structure.

The new wing will face Superior St. and connect with the present Montgomery Ward Memorial and Morton Medical Research buildings on 7 of its total 15 stories. It will contain 92,000 square feet of usable space.

The main feature of the new "unit" or multidisciplinary laboratories for first and second year medical students will occupy two complete floors. Each unit laboratory will house 16 students on a "homeroom" basis. Space also will allow for the teaching of basic medical sciences in the same room. Another feature will be expansion of the Medical School library on the entire first floor, which will double the capacities of the reading room and stacks. A new rare book room also will permit housing and display of more than 10,000 rare volumes, drawings, and manuscripts valued at more than $250,000.

The remaining 12 floors will permit expansion of research in heart disease, tuberculosis, cancer, muscular dystrophy, Parkinson's disease, surgery, and many other areas of major medical research.

Northwestern hopes to begin construction in the spring of 1962.

Dr. Schulman to head department

Dr. Irving Schulman, Glencoe, has been appointed head of the department of pediatrics, University of Illinois College of Medicine. He will replace Dr. Heyworth N. Sanford, who is scheduled to retire. Dr. Schulman is currently professor of pediatrics at Northwestern University Medical School and director of hematology at Children's Memorial Hospital. His appointment is effective September 1. Following his graduation from New York University College of Medicine in 1945, he served as an instructor there and at Cornell University Medical College. He came to Northwestern in 1958.

State Council reviews hospital planning

The Illinois Advisory Hospital Council met in July in Springfield to review the 13th annual state plan for the construction of hospital and medical care facilities in Illinois.

In order to participate in the Hill - Burton program, each state must survey its need for these facilities, develop and keep current a state plan listing hospital and medical facilities, and set forth a coordinated program for construction of additional facilities.

Consideration of the plan by the council and approval by Dr. L. L. Fatherree, director of the Illinois Department of Public Health, and the Surgeon General of the U.S. Public Health

Service, will enable Illinois to participate in federal funds appropriated by Congress. On the basis of bills introduced, Illinois' share will be between $5 million and $6 million for the 12 months beginning July 1.

Illinois communities will share in this allotment on the basis of need for facilities as established by the state plan priority schedule. Both nonprofit associations and governmental agencies are eligible applicants for these funds.

Society elections

The 1961-62 officers of the Chicago Medical Society are Dr. Patrick H. McNulty, president; Dr. Casper M. Epsteen, president elect; Dr. Allison L. Burdick, secretary; and Dr. Edward W. White, treasurer.

The Chicago Surgical Society elected the following physicians as its 1961-62 officers: R. Kennedy Gilchrist, president; Chester C. Guy, vice president; Frederick W. Preston, secretary; Paul V. Harper of Glencoe, treasurer, and Paul F. Fox, recorder.

Dr. Grayhack first Kretschmer Professor

Dr. John T. Grayhack, La Grange, has been appointed chairman of the department of urology at Northwestern University Medical School, succeeding Dr. Vincent J. O'Conor who is retiring.

The appointment is effective September 1 and coincides with establishment of the Herman L. Kretschmer Chair of Urology, in which Dr. Grayhack will serve. The chair is named in honor of the world renowned Chicago urologist, former president of the American Medical Association and a Northwestern alumnus, who died in 1951. He donated more than $1.2 million to Northwestern in honor of his wife Lucy and son Edwin for research and special studies in urology.

Dr. O'Conor will continue in private practice and in teaching and research at the medical school and Wesley Memorial Hospital.

An associate professor of urology, Dr. Grayhack is director of the Kretschmer Laboratory and attending urologist at Passavant Memorial Hospital and at Veterans Administration Research Hospital. A graduate of the University of Chicago, he did graduate work at Johns Hopkins hospital and medical school, where he was a fellow of the American Cancer Society and a member of the teaching staff.

Physician-Pastor research project

The Rev. Dr. Granger E. Westberg, La Grange, associate professor of health and religion at the University of Chicago, is conducting a research project in La Grange for seventeen clergymen from that area who are taking a special postgraduate course at the university on "The Clergyman's Responsibility in the Field of Health." This is combined with weekly seminars at the local Community Memorial Hospital which have been meeting for a year and will continue to meet for another year. In them physicians join the clergymen for discussions of types of illnesses where the joint resources of pastor and physician can be used to aid the patient. The project is sponsored by the U.S. Public Health Service as a pilot study to test the possibility of inaugurating similar seminars of physicians and clergymen in local hospitals throughout the country.

Dr. Westberg, who recently published a book on this subject, "Minister and Doctor Meet," has a professorship at the university which combines teaching on both the medical and divinity school faculties.

Awards

Miss Stella L. Brueggen, R.N., for 15 years a member of the staff of the Illinois Society for the Prevention of Blindness, Chicago, has received the 1961 Mary M. Roberts Fellowship Award in Journalism—the first nurse from Illinois ever chosen from the national competition. The fellowship is given by the American Journal of Nursing Company to assist qualified nurse writers in skillfully interpreting nursing to their profession and the general public. The award includes full tuition fees for a year's study at a recognized school of journalism of the winner's choice, $3,000 to cover living expenses during the study year, and a three to six month internship on the journal's New York staff.

Miss Brueggen will also end her consultant duties to the Illinois Eye Bank, where she served as a consultant for the past five years, and to the Chicago Board of Education and the Archdiocesan School Board. She will enroll this fall in Northwestern University's Medill School of Journalism. Upon completion of her studies she plans to continue in public health nursing, specializing in eye care.

Miss Brueggen has a B.S. degree in public health nursing from Loyola University and did a year's postgraduate work at Cook County School of Nursing.

Forest Hospital appointment

Dr. Ralph C. Greene has been appointed consultant in pathology at Forest Hospital, Des Plaines. He is currently associated with Ingalls Memorial Hospital and Holy Family Hospital, also in Des Plaines. He is a fellow of the College of American Pathologists and is certified by the American Board of Pathology.

Macon

New 50-Year Club members

Three physicians were honored for 50 years of practice at a meeting of the Macon County Medical Association in June. The new members of the 50-Year Club are Dr. R. Zink Sanders and Dr. I. H. Neece, both of Decatur, and Dr. Sylvester J. Henry of Effingham. They were presented pins and a certificate from the Illinois State Medical Society.

Dr. Sanders is past president and secretary of the Macon County Medical Society and has had an active part in city affairs. He is now president of the Park Board.

Dr. Neece has been active in medical organizations on local and state levels and was once physician for the city of Decatur. He is past president of the Illinois State Medical Society and has served on the Illinois division of the American Cancer Society.

Dr. Henry has been in practice in Effingham since 1911.

Dr. Andrew Hall, Mount Vernon, was speaker at the meeting.

Dedicate 300-bed hospital

The new $7.5 million St. Mary's Hospital was dedicated August 5 and a public open house was held August 6 in Decatur.

Construction of the 300-bed hospital began in the summer of 1958. During 1957, Decatur's largest fund drive resulted in a $1.5 million citizen, industrial, and business donation for the hospital. Additional funds were provided by the Hospital Sisters of the Third Order of St. Francis, operators of St. Mary's, and several other hospitals in the Midwest.

Morgan

Name change

The name of the Norbury Sanatorium, Jacksonville, has been changed to the Norbury Hospital because it was felt this better expressed the Institution's orientation toward short-term intensive psychiatric therapy as contrasted to full-time custodial care that was formerly given patients.

Grants for mental health service

Grants amounting to $1,598,200 have been allocated for community mental health clinics and other special mental health services in the state, effective July 1. They show an increase of $335,000 over similar grants for the past year.

Clinic grants total $1,434,250, about 80 per cent of which comes from the state mental health fund and the remainder from federal funds. Local funds from such sources as United Fund, Community Chest, fees and contributions from individuals and groups will amount to $1,395,674.

A community clinic being developed at Aurora will receive a grant for the first time, raising the total to 32 such mental health units in this community-based program. More than 12,000 patients were seen last year in these clinics, about 1,000 on conditional discharge from state hospitals.

Additional grants totaling $163,950 for special mental health services were allocated to the following in Chicago: Retarded Children's Aid, Hull House, for a day center for retarded adults, $37,500; Jewish Vocational Service for rehabilitation services to conditionally discharged patients from state hospitals, $18,000; National Council of Jewish Women, The Thresholds, for a day center for the mentally ill, $20,000; Illinois Children's Aid Society, for psychiatric outpatient services for adolescents in residential program, $19,000. Others are Southern Illinois University, Carbondale, for community mental health plays program, $1,450; Peoria Association for Mentally Retarded, East Peoria, for training program for pre-school and young adult mentally retarded, $45,000; Illinois Department of Public Health for mental health film library, $5,000, and the Department of Public Welfare for use in training grants and mental health education, $18,000.

Communities interested in grants for local clinics may obtain information by writing Charles R. Meeker, Administrator, Community Mental Health Services, 403 State Office Building, Springfield.

General

Impartial medical testimony rule adopted

The Illinois Supreme Court on June 6 adopted Rule No. 17-2 pertaining to impartial medical testimony to become effective on September 5. It is as follows:

"When in the discretion of a trial court it appears that an impartial medical examination will materially aid in the just determination of a personal injury case, the court, a reasonable time in advance of the trial, may on its own motion or that of any party order a physical or mental examination of the party whose mental or physical condition is an issue. The examination shall be made without cost to the parties by a member or members of a panel of physicians chosen for their special qualifications by the Illinois State Medical Society. The court administrator and the deputy court administrator are charged with the administration of this Rule.

"A copy of the report of examination shall be given to the court and to the attorneys for the parties. Should the court at any time during the trial find that compelling considerations make it advisable to have an examination and report at that time, the court may in its discretion so order. Either party or the court may call the examining physician or physicians to testify, also without cost to the parties. Any physician so called shall be subject to cross examination. The court shall determine the compensation of the physician or physicians."

By the adoption of the rule, impartial medical testimony in Illinois is extended to all of the Circuit and Superior Courts of this state. This is the culmination of several years of hard work by the Society's Committee on Impartial Medical Testimony headed by Dr. Samuel Levinson, who succeed Dr. Richard J. Bennett.

New AMA officers

Dr. Leonard W. Larson of Bismarck, N.D., was installed as president of the American Medical Association at its anuual meeting in June. Dr. George M. Fister of Ogden, Utah, member of the AMA Board of Trustees and previously a member of the House of Delegates, was named president elect.

Two Illinois physicians became officers. Dr. Percy Hopkins, Chicago, was elected vice chairman of the Board of Trustees, and Dr. Burtis E. Montgomery of Harrisburg was elected to the Council on Medical Service.

Mrs. English calls for more community service

In taking office as the president of the Woman's Auxiliary to the American Medical Association, Mrs. Harlan English, Danville, called on members across the country to develop strong local public service programs built on community needs.

A number of community projects that doctors' wives can take on voluntarily were cited by Mrs. English. They include homemaker service programs; practical programs to help meet nutritional and recreational needs of older persons; civil defense educational programs; mental health activities, especially those dealing with alcoholism; programs for safety, poison control and water safety; fund-raising for medical education.

Mrs. English succeeds Mrs. William Mackersie of Detroit. The new president elect is Mrs. William G. Thuss, Birmingham, Ala.

Illinois physicians at annual meetings

Dr. Charles K. Petter, medical director, Lake County Tuberculosis Sanatorium, Waukegan, was elected first vice president of the American College of Chest Physicians at its annual meeting in New York in June. Treasurer and assistant treasurer are Dr. Albert H. Andrews, associate clinical professor of bronchoesophagology, University of Illinois College of Medicine, and Dr. William E. Adams, Raymond, professor of surgery, University of Chicago School of Medicine.

Dr. Edwin R. Levine, assistant professor of clinical medicine, Chicago Medical School, won first prize for his film "Hypoxia—Indications for Oxygen Therapy" at the annual meeting of the American College of Chest Physicians in New

York. The awards for scientific motion pictures were conferred by Dr. Paul H. Holinger, chairman of the Committee on Motion Pictures, in an award ceremony during the Presidents' Banquet at the Commodore Hotel June 25.

Dr. Lindon Seed, associate professor of surgery at the University of Illinois, was elected president of the Society of Nuclear Medicine at its annual meeting in Pittsburgh. Dr. Y. T. Oester, Chicago, was elected to the Board of Trustees at the meeting.

Deaths

Nathaniel I. Baskind*, Chicago, a graduate of the University of Illinois College of Medicine in 1913, died June 28, aged 69. He had practiced in the Englewood area over 40 years was on the board of trustees of the Chicago Medical School since 1952. He and his wife established a medical scholarship fund at the University of Chicago, and in 1959 he was awarded a plaque by the Valentine Boys Club for his work with youth.

B. Barker Beeson*, Riverside, a graduate of the University of Illinois College of Medicine in 1906, died July 2, aged 78. He was a former professor and director of the department of dermatology at Loyola University's Medical School and was attending dermatologist at Mercy Hospital and chief of the skin disease department at Cook County Hospital.

John H. Brantley*, retired, La Jolla, Cal., a graduate of the St. Louis College of Physicians and Surgeons in 1895, died September 27, aged 88. He was an emeritus member of the Illinois State Medical Society and a member of its 50-Year Club.

Joseph M. DiMarca*, Chicago, a graduate of the Royal University of the Palermo Medical School, Italy, in 1923, died May 14, aged 65.

Edward V. Donovan*, Chicago, a graduate of the University of Illinois College of Medicine in 1920 died November 9, aged 66.

Leo J. Fuller, Chicago, a graduate of the Chicago Medical School in 1918, died February 15, aged 72.

Russell D. Herrold*, Chicago, a graduate of the Rush Medical College in 1915, died September 28, aged 71. He was an attending physician at St. Joseph Hospital, Chicago, and for many years was on the urological staff of Cook County Hospital. From 1922 to 1926 he was an instructor at the University of Illinois College of Medicine, assistant professor of genitourinary Surgery there from 1927 to 1935, associate professor from 1935 to 1957, and professor emeritus until his death. He was a consultant in venereal diseases to the U.S. Public Health Service for almost 25 years. He was president of the Chicago Urological Society from 1927 to 1928 and its secretary during World War II. From 1949 to 1950 he was president of the American Urological Association and secretary of its North Central Section from 1946 until then.

Henry H. Hurd*, retired, Virgin Islands, a graduate of the St. Louis University School of Medicine in 1927, died June 22, aged 62. He had practiced in East St. Louis for 40 years before retiring.

Gerald W. Jankowicz, Chicago, a graduate of the University of Illinois College of Medicine in 1949, died July 2, aged 37. He was on the staff at Northwestern University Medical School.

William G. Kraybill*, Pittsfield, a graduate of the Temple University School of Medicine, Philadelphia, in 1938, died June 6, aged 47. He was a resident surgeon at the Bishop Clarkson Hospital in Omaha, Neb., in 1940 and at the University of Nebraska Medical School in 1941, also teaching surgery there until 1944. He had lived in Pittsfield since 1944 with the exception of 1953-55, when he served as consultant for the Third Air Force at the United States Surgical Park in Wimpole Park, England.

He was a member of the Illinois Surgeons Society, the Rotary Club, the Pike-Calhoun Medical Society, a fellow of the American College of Surgeons, and a diplomate in surgery. This spring he received the first Mary Barkely award from Pittsfield high school given to a citizen for outstanding interest in education. He served on the school board there from 1957 until 1960.

Clifford R. Layton, Chicago, a graduate of the Chicago College of Medicine and Surgery in 1910, died June 1, aged 74. He had practiced in Chicago over 50 years, half of which were spent with the city health department before going into private practice 25 years ago.

Benjamin M. Nadler, Chicago, a graduate of the Chicago College of Medicine and Surgery in

1912, died June 21, aged 78. A north side physician for over 50 years, he was on the staff of Franklin Boulevard Hospital.

CHARLES NEUMANN*, Chicago, a graduate of the Reliance Medical College in 1909, died January 13, aged 91.

EDMOND E. RICHARDSON*, Mattoon, a graduate of the Hahnemann Medical College in 1903, died October 9, aged 86.

PHILIP A. ROSE*, Chicago, a graduate of the Northwestern University Medical School in 1906, died June 7, aged 63.

GEORGE ROSEN*, Chicago Heights, a graduate of the Chicago Medical School in 1939, died March 2, aged 51.

HYMAN I. SAPOZNIK*, Chicago, a graduate of the Loyola University School of Medicine in 1929, died June 22, aged 56. He practiced in Chicago 25 years and was an attending physician at Michael Reese Hospital. He was medical director of Fox River Hospital in Batavia and was on the staff of Weiss Memorial Hospital.

EDWARD H. WARZNIAK*, Chicago, a graduate of the Chicago Medical School in 1933, died June 24, aged 56. He was on the staff of the Central Community Hospital.

JOHN C. WILLIAMSON*, retired, Toulon, a graduate of Loyola University School of Medicine in 1921, died October 10, aged 70.

RAYMOND F. WRIGHT, retired, Chicago, a graduate of the Illinois Medical College in 1910, died June 17, aged 79. He had been chief medical officer for the Chicago Board of Health for 42 years before retiring four years ago.

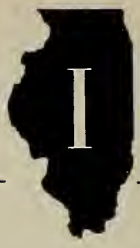
**Indicates member of Illinois State Medical Society.*

Holiday cholesterol

The only recent reference to seasonal cholesterol patterns found is a report by Means and Andrews who attempted to determine, in ewes, whether a theoretical increase of thyroid activity during cold weather is accompanied by a decrease in cholesterol level. They reported no significant difference in the seasonal cholesterol levels of ewes living in a naturally fluctuating environment. Their data, however, show that the highest mean cholesterol level for several groups of ewes occurred on December 21, with other high levels in March, April, and October. The lowest levels for these same groups occurred in May and September. Their findings, therefore, are somewhat similar to ours.

From our limited observations there was no striking correlation between the amount of physical activity and the cholesterol level. It is also open to question whether seasonal changes in dietary fat or stress at the Christmas season played any important role. It seems quite possible that there are other biologic or technical factors more closely associated with the observed seasonal trend of cholesterol level than those so far considered. *Caroline B. Thomas, M.D., et al. Observations on Seasonal Variations in Total Serum Cholesterol Level Among Healthy Young Prisoners. Ann. Int. Med. March 1961.*

BOOK REVIEWS



Modern Occupational Medicine. A. J. Fleming, C. A. D'Alonzo, and J. A. Zapp. $12. Pp. 587. Philadelphia, Lea & Febiger, 1961.

This volume is written by contributors who have had extensive experience in the occupational aspects of medicine, especially as related to the chemical industry. The experience is largely that originating from the E. I. du Pont de Nemours & Company.

In addition to the professional medical duties which occupy a great deal of the industrial physician's time, there are medical and administrative phases of concern such as industrial relations, employee relations, preventive medicine, and research in degenerative diseases. These subjects are adequately and concisely covered by the contributors. Chapters deal with such phases as organization of a medical department for industry, the physical environment of the worker, toxicology, poisoning, biostatics, emotional and psychiatric problems, and industrial noise. The material related to the industrial back is of value as well as a discussion of medico-legal problems. For any physician practicing in an industrial environment this book will certainly be of value.

W. Harrison Mehn, M.D.

Textbook of Pathology. William Boyd, M.D. Ed. 7. $18. Pp. 1357. Philadelphia, Lea & Febiger, 1961.

This textbook has been a favorite of students for almost two decades. It has been revised and as the author states, "rewritten with function as well as structure in mind."

Part I now is entitled "Principles of Pathology" because general principles governing diseases are stressed. Part II, entitled "Regional Pathology," deals with the practical application of the theories and principles mentioned in Part I.

This book, as with other editions, reveals that Boyd was an internist before going into pathology. He views pathology as physiology gone wrong. The basic features of pathologic lesions are well described, but the book is enhanced by the way in which the author correlates symptoms with the disordered function of the diseased structures.

New chapters have been added to the book in keeping with advances in medicine. The chapter on immunity and hypersensitivity, for example, brings us up-to-date on hypersensitivity, autoimmunity, autoimmune diseases, and tissue transplantation. Less space is given to old diseases, and many of the old pictures and colored plates were discarded.

The clinician who has been out of school fifteen or more years will enjoy the refresher course that can be obtained from a book of this type. There is enough of the clinical to make the pathologic interesting.

T. R. Van Dellen, M.D.

Fundamentals of Nerve Blocking. Vincent J. Collins, M.D. $9.50. Pp. 354. Philadelphia, Lea & Febiger, 1960.

This is a book which will serve as a text and source book for those interested in techniques, principles, and problems involved in nerve blocking for regional anesthesia and therapeutic purposes. The volume is well organized. A section deals with principles and problems of nerve blocking and includes an interesting section on the development of procedures now utilized. Another section discusses anesthetic agents with

methods of potentiating the action along with the toxicology of these agents. Actual techniques are illustrated and described for most areas of the body. In addition, indications for the procedures are given with methods of determining the degree of success.

This volume will serve well the physician or student who is seeking additional information and guidance in the use of nerve blocking both for anesthesia and therapy, and it will be of special value to those who are in a training program and those who are actually engaged in the practice of anesthesia.

W. Harrison Mehn, M.D.

Meaning and Methods of Diagnosis in Clinical Psychiatry. Thomas A. Loftus, M.D. $5. Pp. 169. Philadelphia, Lea and Febiger, 1960.

This compact and unusual little book, new on the scene, is as welcome to the reader in general psychiatry as the new compact car to the driving public. After a rich experience in teaching of undergraduates and residents, and his work with psychoanalytic trainees, Dr. Loftus has assembled his observations into an easily read and understandable little volume.

This compendium of experience together with current beliefs and even conflictual material is presented to the reader in a fashion that is not difficult to follow. For example, Dr. Loftus emphasized in Chapter I, entitled "The Meaning and Method of Diagnosis," that there is little specificity but instead confusion as to diagnosis because of the variables in the sociological situation. He spends almost one third of the book defining disease concepts, methodology in diagnosis, and definition of terms. The usual symptom complexes present in most classifications are clearly, but briefly, defined, and the author emphasizes that each of these groups may merge into each other and are not clear cut. He tells the reader to remain flexible in his thinking so that management and therapy can be directed not only to the working but also to the final diagnosis. Chapter I is designated as the reference source for the balance of the book.

Of almost equal weight, is the next major area which includes chapters on Psychiatric History Taking, The Psychiatric Examination, and Comparative Histories, each illustrating some specific reaction type. Dr. Loftus compares the taking of a history to a definite laboratory exercise. Finally, there is a brief chapter on the Psychiatric Consultation, Emergency Consultation, Doctor-patient Relationship, and the use of Drugs in Diagnosis.

This book will never become a standard textbook but is intended to supplement standard texts in general psychiatry diagnosis. It is useful to the undergraduate because it is easy to absorb, and the student can utilize the psychopathology presented. The psychiatric resident should own this little book so easy to use in the busy day. Even the general practitioner who is attempting to have a knowledge of the direction in psychiatry at present would do well to obtain this book. For the psychiatrist who subscribes to only one specific point of view, Dr. Loftus is much too eclectic. Regardless, this volume is so well written, so understandable, and so carefully prepared, that it is easily recommended.

Louis D. Boshes, M.D.

Sea Within. William D. Snively, Jr., M.D. $3.95. Pp. 150. Philadelphia and Montreal, J. B. Lippincott Company, 1960.

This slim, well illustrated monograph explains the complex story of our internal fluid environment. That it briefly and clearly does so is a tribute to the author, an Indiana neighbor and graduate of the University of Illinois and Northwestern University. He has undertaken the task of exposition of this intricate subject so that this book might be of value to scientifically interested lay persons as well as to students for use as an introductory background text. The purpose has been achieved, and the product is a genuinely interesting, scientifically accurate, well-indexed volume which is easily read in one evening.

Early in the book the author justifies the metaphor of the title. Then he avoids the trap of complicating his subject by entanglement with too much allusion and simile. Thereupon he leads the reader down the circuitous paths of fluid compartmentation, ionic theory, fluid secretion and excretion, and units of measure. This is done without confusion by use of commonplace, often homely, examples which keep the text interesting.

Pathologic abnormalities of water deficit and excess, electrolyte deficit and excess, and alkalo-

sis and acidosis are explained. It is amazing that such clarity of thought and simplicity of presentation has eluded more sophisticated medical texts on this same subject.

After touching briefly on the subjects of vitamins, calories, and hypoproteinemia, the author explains how physicians deal with abnormalities of the body fluids. He emphasizes treatment of the patient rather than treatment of the laboratory report. Finally he indicates that our knowledge of body fluids is a relatively recent acquisition when viewed in its relationship to recorded time, and that profound though this knowledge is, it merely hints at the revelations which are yet to come.

This book can be recommended to students, nurses, and to those physicians who desire a brief nontechnical review of this lengthy, complex subject.

John J. Bergan, M.D.

The Merck Manual. Ed. 8. $7.50. Pp. 1,900. Rahway, N. J., Merck & Co., Inc., 1961.

The tenth edition of The Merck Manual, containing contributions from over 100 authorities in various medical fields, was published this spring. The new edition has grouped into one chapter several hundred carefully selected prescriptions, including the most recent medicinal advances, and combined it with nine special therapy chapters into one section. Previously, prescriptions had been divided among the main sections of the manual.

The new volume contains 384 chapters on the diagnosis and treatment of diseases. Chapters are grouped into 21 thumb-indexed main sections, each covering a specific field of practice. Over 20 new subjects, additional tables, and original illustrations have been added, and other material has been revised or updated. Part II presents suggestions on medical procedures and techniques with practical reference materials and tables.

The Choice of A Medical Career. Essays on the Fields of Medicine. Edited by Joseph Garland, M.D., and Joseph Stokes III, M.D. $5. Pp. 231. Philadelphia, J. B. Lippincott Company, 1961.

Chapter One, "The Art and the Science," by Dr. C. Sidney Burwell excellently summarizes the changes that are occurring in the structure and function of American medicine and the role of educators in meeting these changes. The importance of the physician in the prevention, diagnosis, and management of illness and also to both the patient and the family in which health and illness take place all receive the proper emphasis. The last chapter by Dr. William B. Bean, "Caritas Medici," concludes the little book in this same vein.

The essays in between those by Drs. Burwell and Bean, constitute rather detailed descriptions of the nature and preparation for 19 of the principal specialty areas of medicine — including an essay on "General Practice" by Dr. Daniel M. Rogers and another on the basic "Medical Sciences" by Dr. W. Barry Wood, Jr. These chapters emphasize the fact that the totality of knowledge important to medicine has long outreached the intellectual capacity of any one man and tells how this knowledge has had to be fragmented into learnable parts. Hence the specialism which now characterizes modern medical practice.

It is probable that, except for the essays of Drs. Sidney Burwell, Barry Wood, and William Bean, this book will be of greater interest to young people already committed to the study of medicine than to those who may still be uncertain.

Ward Darley, M.D.

'Tis not what man does which exalts him, but what man would do! — *Robert Browning*



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Reference: 1. Scal, J. C.: Eye Ear Nose & Throat Month. **38**:738 (Sept.) 1959.

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In the most superficial burn scars, in which the hair follicles and sweat glands have not been destroyed, basal cell carcinomas may develop. *Salvador Castanares, M.D. Malignant Degeneration in Burn Scars. California Med. March 1961.*

Costly controls

Cost of the Con Edison (NewYork) air pollution control program, undertaken since the establishment of the department, is approximately $60,000,000. Since 1937, Con Edison has spent in excess of $100,000,000 on air pollution control. In spite of this expenditure, the general public is not aware of this continuing program, and much of the publicity given to it has come from the Department of Air Pollution Control. Because of the department's belief that more publicity should be given to the program, the department during 1960 constantly called upon Con Edison to make the facts known, and time was given to the air pollution control program on Con Edison's news and weather shows on radio and television. In spite of this, the department still believes that more must be done by Con Edison to acquaint the public with the cost and work involved in this air pollution control program. *1960 Annual Report of the City of New York's Department of Air Pollution Control. Vol. VII, No. 5. May 1961.*

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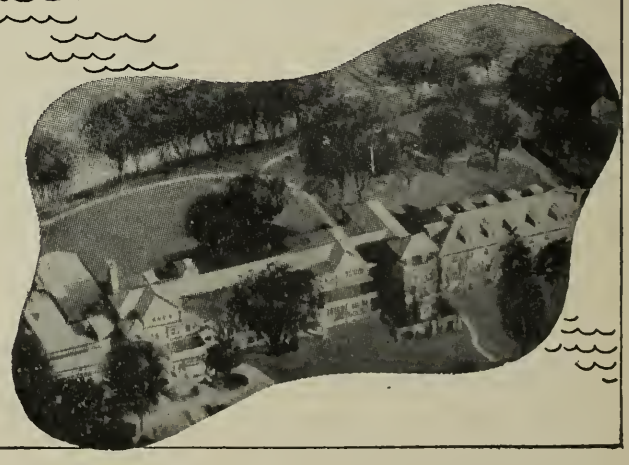
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Identifying problem-drunks

Alcohol in the blood at work was also seen as a serious threat to job security; the scale revealed that frequent use of alcohol during the work day or before going to work did not occur until personality, physical and hangover signs were substantially present. However, alcohol in the blood was not generally conceived to be as serious a job threat as excessive absence. Thus drinking before or during the work day was risked because it served the function of enabling the man to be at work, thereby avoiding the greater risk of more absenteeism.

The most significant observable signs of drinking before or during the work day included the aroma of alcoholic beverages on the breath, the aroma of breath "purifiers" or "covers," the avoidance of supervisors or associates, and striking mood changes during the day. The most common observable physical or behavioral signs were red or bleary eyes, flushed face, hand tremors, increased nervousness, greater irritability, more spasmodic work pace, procrastination, and neglecting details formerly attended to. To this could be added noticeable deterioration in work performance.

It is concluded that these findings may be utilized in the early identification of problem-drinking employees. Although absence or most of the physical or personality signs can occur for reasons other than problem drinking, when either substantial absenteeism or physical or personality signs are accompanied by repeated evidence of hangover or drinking before or during the work day, there is reason to suspect a drinking problem. In the present study group, 72 per cent could have been detected on this basis alone. *Milton A. Maxwell, Ph.D. Early Identification of Problem Drinkers in Industry. Quart. J. Stud. Alcohol. Dec. 1960.*

If we want to utilize in the proper way and to the fullest extent the products of man's intellect, we must develop that part of man's being that is his heart and spirit. — *Ferdinand Pecora*

Our life is what our thoughts make it. A man will find that as he alters his thoughts toward things and other people, things and other people will alter towards him. — *James Allen*

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Published monthly by the Illinois State Medical Society, 360 N. Michigan Avenue, Chicago 1, Ill. Subscription $5.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, and Mexico. $7.00 per year for all foreign countries included in the postal union. Canada, $5.50. Single current copies 75 cents.

Second class postage paid at Mendota, Illinois. POSTMASTER: Send notices on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago 1, Ill.

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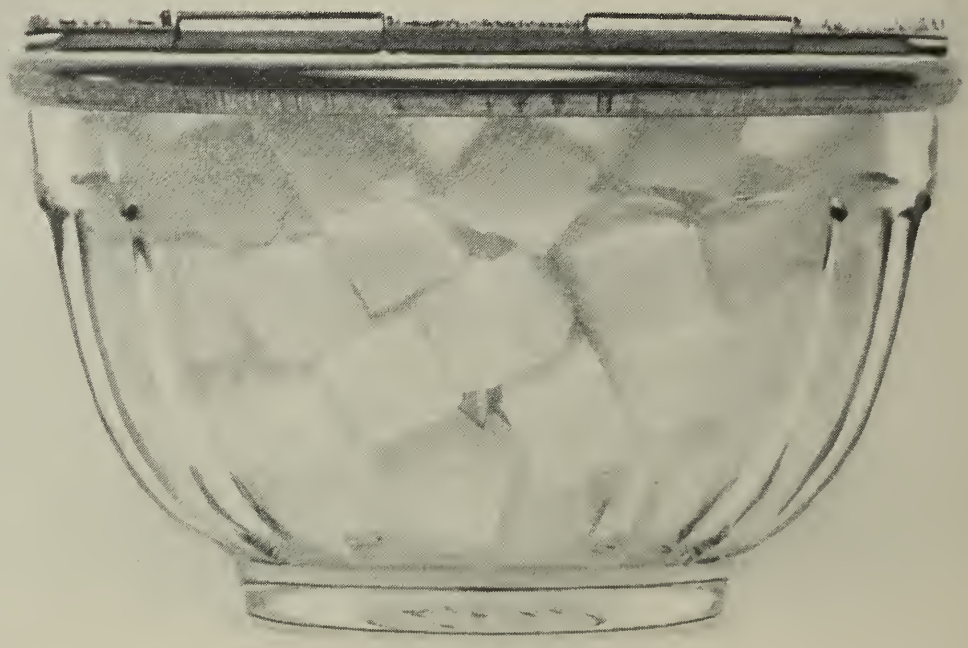
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(1) Danowski, T. S.: Diabetes Mellitus, Baltimore, Willlams & Wilkins, 1957, p. 239. (2) McCune, W. G.: M. Clin. North America 44:1479, 1960. (3) Ackerman, R. F., et al.: Diabetes 7:398, 1958.

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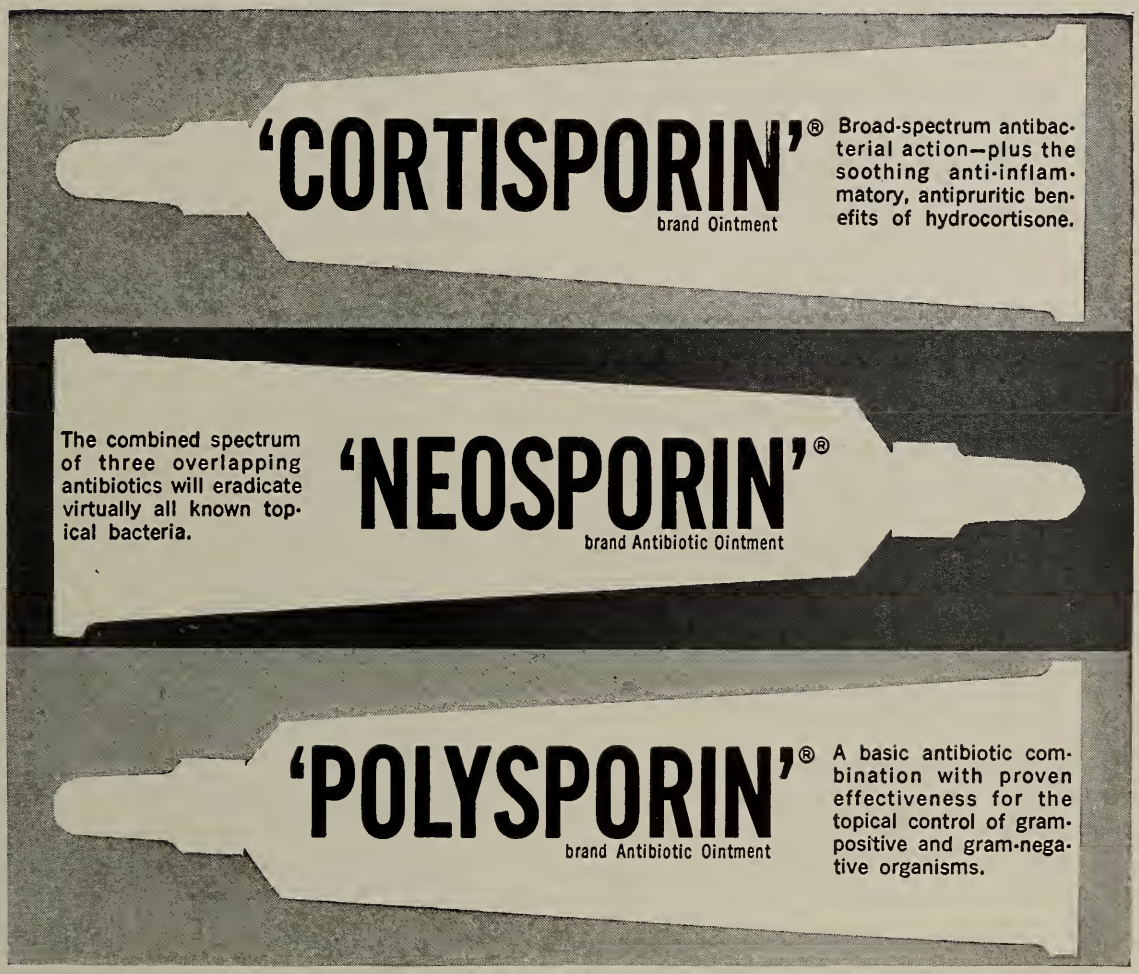
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The Month in Washington



The American Medical Association cited more than 50 reasons why the vast majority of the nation's physicians believe the Administration's medical care program would be "bad medicine for the people of this country."

The AMA's objections to the proposal were spelled out in a detailed, 91-page printed statement presented to the House Ways and Means Committee by Dr. Leonard W. Larson, Bismarck, N.D., president of the AMA.

The committee held two weeks of hearings (July 24-Aug. 5) on the Administration proposal (H.R. 4222) which would provide limited hospitalization, nursing home care, and outpatient diagnostic services for social security recipients. The program would be financed by an increase in payroll taxes on workers, employers, and the self-employed.

Dr. Larson declared that the Administration program would force upon Americans a system of health care in which the quality of medical care would deteriorate, in which quality would become secondary to cost.

He said American medicine is the best in the world, medical education unsurpassed, and the qualifications of U.S. physicians unmatched. "Ours is a dynamic system of health care — and it works," he said. "The very fact that we now have 16½ million Americans 65 years of age and older proves that it works.

"Yet, this same system of medical care is now under attack. At a moment when American medicine is pre-eminent throughout the world, it is proposed that we adopt the very systems under which one European nation after another has lost its former leadership in medical science.

"The staggering costs of such plans, the administrative problems they create — let these considerations be secondary", he said. "The important thing is to see, at close range, the disruption of the doctor-patient relationship; the delays in admission to hospitals; the time wasted in the over-crowded offices of doctors; the regimentation of medical practice; the effect of the program on medical research; the availability of medical facilities and personnel — in other words, medicine in action on a government-run, assemblyline basis."

Dr. Larson said also:

1. Congress is being asked to plunge into a compulsory government-operated program of health care for certain of the country's elderly without knowing what even the first-year cost will be—whether $1 billion or $4 billion—and without any clear idea of the extent of the problem it seeks to solve.

2. The bill under consideration would give a single government official the power to "become the nation's czar of hospital care."

3. Contrary to statements of supporters of the measure that physicians' services are not included in the program, more than 50,000 doctors would be directly affected by regulations and controls exercised by governent over operations and administration of hospitals.

4. Enactment of the program would "lower the quality of medical care available to the older people of the United States" because "it would introduce into our system of freely practiced medicine elements of compulsion, regulation, and control" by government.

5. The Administration proposal is unnecessary in light of the true economic status of the aged and because of the spectacular rise of voluntary, private health insurance coupled with passage by Congress of the Kerr-Mills Medical Aid for the Aged Law last year and the existence of other

(*Continued on page 22*)



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public and private programs of aid to the needy.

6. Health care at the expense of the working people would be provided for millions who are financially able to pay for their own care.

7. The legislation "proposes that we distrust the brains and capacities to today's Americans" because "it suggests that the aged—as an entire group—are not capable of looking after their own affairs and providing for their own needs."

8. Increasing costs of the program could impose such a financial strain on social security that the entire system could be jeopardized.

9. The Administration's bill is just as objectionable as the five similar health care proposals rejected by Congress since 1942.

10. The bill would violate "American ideals of independence, self sufficiency, and personal responsibility" by establishing a system in which medical aid would be provided not on the basis of need but on the basis of age.

Dr. Larson described estimates of the cost of the Administration program as "confusing."

The AMA president reminded committee members that HEW Secretary Abraham Ribicoff had told them that "a closer study" had revealed it would be necessary to increase the taxable wage base from the present $4,800 to $5,200, rather than the $5,000 fixed in the bill when it was introduced.

He also pointed out that HEW originally had said nursing home services during the first year of operation of the Administration scheme would cost $9 million. But in May, Dr. Larson said, HEW officials reported the figure as "unrealistically low" and lifted it to "somewhat between $25 million and $255 million."

"Obviously this estimate is something less than precise," Dr. Larson said.

The AMA president said that supporters of the Administration proposal have built their case on five false premises: (1) that the sociological problems of older people can be solved through legislation; (2) that most, if not all, of the aged are in poor health; (3) that most, if not all, of the aged are verging on bankruptcy; (4) that the problem of the aged in financing their health costs will get worse before it gets better, and (5) that voluntary health insurance and prepayment plans, private effort and existing law will not do the job that needs doing.

The ILLINOIS Medical Journal

Official Journal of The Illinois State Medical Society

SEPTEMBER, 1961
VOL. 120, No. 3

Uretero-intestinal Anastomosis and Cystectomy for Exstrophy and Neoplasms of the Bladder*

Charles C. Higgins, M.D., *Cleveland*

Dr. Nelson M. Percy, in whose honor this lectureship is sponsored by the Nelson M. Percy Research Foundation, was an outstanding surgeon, a teacher possessed with the enviable trait of inspiring his residents. Perhaps above all, he was respected, admired, and revered by those whose good fortune permitted surgical training under his guidance. Many surgeons from the United States and foreign countries attended his operative clinics at Augustana Hospital. His reputation as a teacher of surgery and surgical principles was evidenced by the large number of interns applying for resident training in surgery at that hospital.

I feel indeed fortunate to have had general surgical training under his guidance, and I deem it an honor and a privilege to deliver this commemorative lecture denoting our respect, admiration, and love for him.

Exstrophy of the bladder

Today I would like to summarize for you my experience over a period of years with "cystectomy and diversion of the urinary stream for exstrophy and neoplasms of the bladder." Exstrophy of the bladder occurs once in every 30,000 to 40,000 births. It is observed four times more frequently in males than in females. My series includes 104 males and 54 females. Although complete exstrophy of the bladder is rarely observed in twins, or in siblings, I have seen it in two sets of twins, and twice in brothers and sisters.

There are three types of exstrophy of the bladder: (1) superior vesical fissure, (2) inferior vesical fissure, and (3) complete exstrophy.

**The Third Annual Augustana Hospital Nelson M. Percy Lecture, Chicago, Nov. 7, 1960. From the department of urology, The Cleveland Clinic Foundation and The Frank E. Bunts Educational Institute, Cleveland.*

The incomplete types (1 and 2) occur rarely, and as the defect is not pronounced, it may be closed by a plastic procedure, thereby restoring normal continuity of the urinary tract. In patients with complete exstrophy of the bladder, the posterior bladder wall protrudes in toto on the abdominal wall (Figs. 1 and 2). The mucosa of the bladder is fiery red, exquisitely tender, and bleeds readily. In some of these cases the normal cellular structure of the mucosa is replaced by squamous epithelium, and mucosa becomes pearly gray. The ureteral orifices may be visible, and from them urine intermittently spurts.



Figure 1. Exstrophy of bladder.

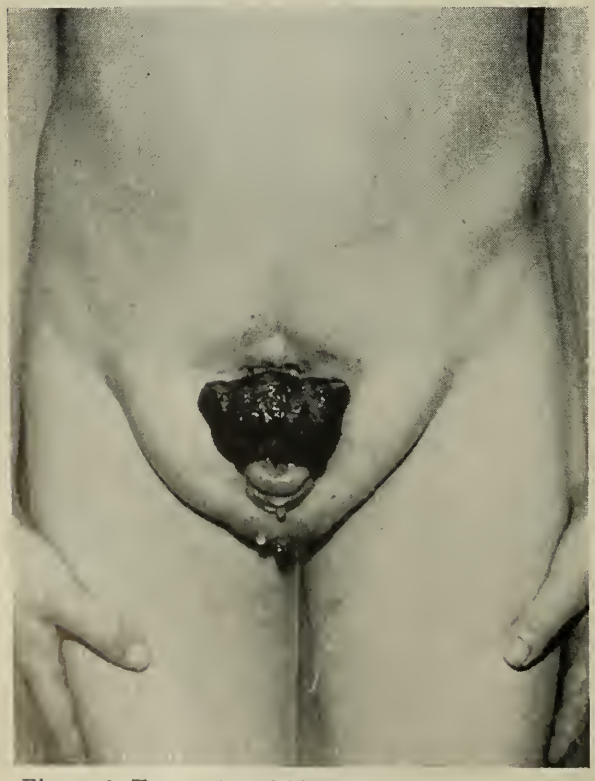


Figure 2. Exstrophy of bladder in child older than the one shown in figure 1.

In boys, epispadias is usually present. Although it has been reported that epispadias is always present in male children with complete extrophy of the bladder, in one boy in this series the penis was normal. In girls the clitoris is cleft, the vaginal orifice being recognized because of the widely separated labia minora. Epispadias was present in all of the girls with complete exstrophy of the bladder in this series. In both sexes the pubes are widely separated, and diastasis of the recti muscles below the umbilicus is present. When the children learn to walk, they have a characteristic waddling gait because of the wide separation of the pubic bones that are joined together only by a fibrous cord, and the outward rotation of the femurs.

Age and surgery

Urologic and nonurologic anomalies are frequently concomitant. In the majority of children the coexisting anomalies can be corrected by appropriate surgical procedures.

Prior to 1950 it was generally advocated that surgical correction for exstrophy of the bladder should be deferred until the child was five or six years of age. Such treatment was recommended despite the clinical observations that many of the children in this age group have recurrent attacks of pyelonephritis followed by impairment of renal function and, in some instances, death. Obviously, in a five to six year old child, the caliber of the ureters is larger and uretero-intestinal anastomosis is not so technically difficult as it is in an infant.

In 1950 I advocated performing uretero-intestinal anastomosis and cystectomy during the first year of the child's life (Fig. 1). The operative morbidity and mortality is extremely low. Futhermore, the ureters are of normal caliber, and the kidneys have not been subjected to repeated insults of pyelonephritis. Uretero-intestinal anastomosis, in my experience, is followed by end results superior to those in which dilatation of the ureters is present at the time of operation.

It has been demonstrated by roentgenographic study that in the majority of patients the dilatation of ureters observed in older children

TABLE 1.—Age ranges of 132 patients at time of ureterosigmoidostomy performed for exstrophy of the bladder.

Age range, years	Number of patients
0 - 1	69
2 - 4	28
5 - 9	15
10 - 14	5
15 - 19	1
20 - 29	7
30 - 39	7
Total	132

is the result of stenosis at the ureterovesical junction of the exposed bladder. In this series nine patients between five and seven years of age required a unilateral ureteronephrectomy because of a large infected hydronephrosis and hydroureter.

It is now generally accepted by the majority of urologic surgeons that the uretero-intestinal anastomosis and cystectomy should be performed during the first year of life. The correction of the chordee and epispadias should be deferred in male children until the penis has attained sufficient size to permit an adequate plastic procedure. In this series of 158 patients, uretero-intestinal anastomosis and cystectomy was performed in 132 patients, their age ranges are listed in table 1.

Complications following surgery

I believe I have encountered the majority of complications that may follow uretero-intestinal anastomosis, particularly in children who underwent operation before introduction of modern antibiotics. The immediately post-operative complications of significance are listed in table 2.

Delayed complications, those observed after patients left the hospital, are listed in table 3.

As noted, hyperchloremic acidosis of significance occurred in 49 patients. However, I do not believe this is the true incidence, since many of the children received postoperatively 10 per cent sodium citrate, orally, the dosage being determined by the follow-up blood chemistries. The medication was discontinued when there was no evidence of hyperchloremic acidosis. Incidence of hyperchloremic acidosis may be reduced by having the child evacuate the bowel frequently during the day and at least once at night.

Of 132 patients 125 left the hospital in satisfactory condition, and 7 died postoperatively: 2 of acute pyelonephritis; 2 in cardiac arrest (during operation several years ago prior to the use of cardiac massage); 1 of bronchopneumonia; 1 following aspiration of vomitus; and 1 of undetermined causes.

After careful review of this series of 158 cases of exstrophy of the bladder, I still prefer uretero-intestinal anastomosis and cystectomy as the primary surgical procedure unless definite contraindications exist. Intravenous urograms of patients in whom the ureters had been implanted into the rectosigmoid at least five years revealed: normal kidneys and ureters in 35.1 per cent; unilateral dilatation of the ureter on one side with no evidence of hydronephrosis in 2.7 per cent; bilateral dilatation of the ureters without hydronephrosis in 2.7 per cent; in the remainder, hydronephrosis from grade 1 to grade 4.

TABLE 2.—Immediately postoperative complications following ureterosigmoidostomy for exstrophy of the bladder.

Complications	Number of patients
Acute pyelonephritis	13
Wound infection	7
Evisceration	5
Leakage, left ureterosigmoidostomy necessitating nephrostomy	3
Strangulated inguinal hernia	2
Acute pyelonephritis (fatal)	2
Otitis media	2
Anuria	2
Cardiac arrest (fatal)	2
Pneumonia	1
Total	39

TABLE 3.—Complications after discharge from the hospital in patients who underwent ureterosigmoidostomy for exstrophy of the bladder.

Complications	Number of patients
Hyperchloremic acidosis	49
Pyelonephritis	39
Uremia	7
Renal calculus	5
Strangulated inguinal hernia	3
Squamous-cell carcinoma of remnant of bladder	1
Papilloma of remnant of bladder	1
Partial intestinal obstruction (adhesions)	1
Intussusception of jejunum	1
Total	107

At the present time when evidence of ureteral obstruction follows uretero-intestinal anastomosis, the ureters are retrieved from the bowel and construction of a Bricker's pouch is recommended. Obviously the ideal procedure would be an operation to permit restoration of the continuity of the lower urinary tract by a plastic procedure. It must, however, be accompanied by uniformly satisfactory results, continence. Let us hope such a technic will be forthcoming in the near future.

Treatment of bladder neoplasms

The treatment of neoplasms of the bladder remains a controversial subject; many and varied opinions prevail concerning both the type of treatment and the selection of patients, particularly in cases of malignant neoplasms. As a general rule, there is less controversy concerning the surgical treatment of benign tumors of the bladder, i.e., papillomata. The majority may be adequately treated by transurethral resection and fulguration.

Occasionally the bladder is so extensively involved, or new tumors form with such rapidity, that this treatment seems ineffective. In these patients I recommend first a course of cobalt-60 therapy. If the response is not satisfactory, I advocate uretero-intestinal anastomosis and cystectomy. I have performed this radical treatment in 12 patients. One patient died of a pulmonary embolism during the postoperative period. Eight patients are living and well and have been free of symptoms for at least five years. One patient has uremia, and two experience an occasional attack of pyelonephritis but respond well to sulfonamide medication.

The unanimity of opinion that prevails in the treatment of papillomata of the bladder is strikingly lacking concerning the management of malignant neoplasms of the bladder. Today I will confine my remarks to my experience, over a period of years, with cystectomy, with or without pelvic gland dissection and uretero-intestinal anastomosis, for the relief of patients with carcinoma of the bladder.

Prior to 1933, cystectomy and uretero-intestinal anastomosis were performed rather infrequently because of the prohibitively high mortality and the high incidence of morbidity of uretero-intestinal anastomosis. In 1933 Coffey[1] advocated the submucous technic for implanting the ureters into the rectosigmoid, and reported a series of patients in whom the radical operation had been performed. This technic was attended by a pronounced lowering of the operative mortality rate and the morbidity. As might be anticipated, following this report, a wave of enthusiasm spread over the country for the radical surgical treatment of carcinoma of the bladder. Unfortunately, however, in many instances a critical analysis of the potential curability, the morbidity, the financial burden to the patient, and a careful appraisal of end results were minimized.

At the present time, this procedure (Fig. 3) has been employed in large series of patients, and sufficient time has elapsed to appraise

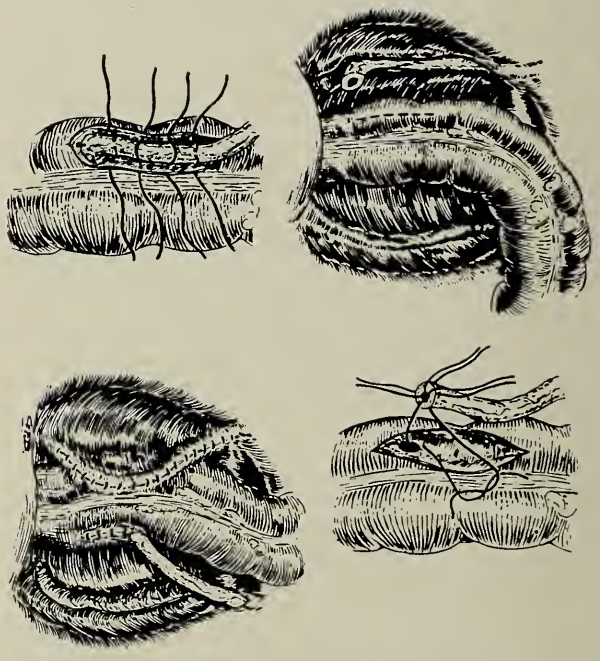


Figure 3. Sketches of operative technique for ureterosigmoidostomy using modification of Coffey 1 operation with mucosa-to-mucosa anastomosis between the rectosigmoid and the ureter. (Courtesy of The Journal of Urology, 80: 282 (Nov.) 1958.)

critically the merits of removal of the bladder and diversion of the urinary stream for carcinoma of the bladder. During the period of preoperative investigation data may be secured which may influence the treatment to be recommended. An intravenous urogram will show the status of the ureters and kidneys. It is generally accepted that multiple biopsies of the neoplasm should be secured. My personal preference is the rectoscope for obtaining adequate biopsy tissue.

It permits securing generously sized specimens not only for cytologic study and gradation of the tumor, but also for determining the degree of neoplastic infiltration.

The degree of infiltration of the bladder wall was discussed by Aschner[2] in 1931. He stressed that the presence or absence of infiltration of the bladder wall was a more reliable guide to the severity of the lesion than that obtained by gradation of the tumor. This observation was confirmed by Jewett and Strong[3] in 1946. They stated, "The clinical determination of the depth of penetration of the bladder wall may provide the index of potential curability." Superficial tumors involving the mucosa of the bladder had a potential curability of 100 per cent; when the invasion was limited to an area between the basement membrane and the external muscle fibers, 88 per cent; while in cases in which the perivesical tissue was infiltrated, 26.3 per cent. The potential curability of an infiltrating neoplasm of the bladder decreases as infiltration by tumor cells progresses toward the periphery. Aschner, as did Jewett and Strong, discussed the importance of the abdominorectal examination under anesthesia to detect the presence or absence of induration, a three-dimensional mass, and induration and thickening of the inferolateral ligament. Classification of the tumor will impart information as to the potential curability and will influence the type of treatment to be instituted.

In the pathologic study of the resected bladders in this series, the following alphabetic-and-numbering system of expressing the histologic dedifferentiation and degree of involvement was used (Fig. 4). This gross grading of tumors, combined with histologic dedifferentiation in accordance with the definitions of Ash, and indicated, as is customary, by Roman numerals, affords a range of grades from the practically benign I-A tumors to the notably infiltrating, poorly dedifferentiated grade IV-D tumors.

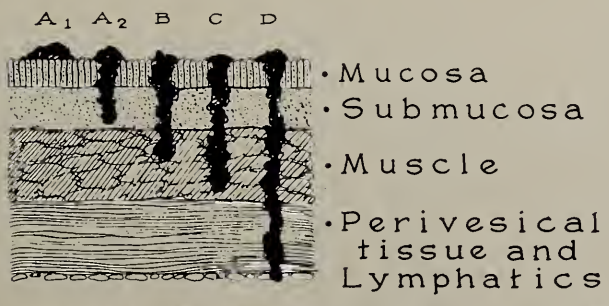


Figure 4. Sketch showing classification of tumors based on invasiveness. (Courtesy of The Journal of Urology, 80: 289 (Nov.) 1958.)

Report of 139 cases

In another series of 139 patients in whom cystectomy with or without pelvic gland dissection was performed, 110 patients have adequate records and pathologic material to review. The radical operation was performed more frequently in men (84) than in women (26). The ages ranged from 51 to 60 years and averaged 55.2 years.

One hundred and one patients were discharged from the hospital in satisfactory condition. Of the 139 patients, 9 died in the immediately postoperative period, an operative mortality of 6.4 per cent. The causes of death were as follows: septicemia (1); bronchopneumonia (1); coronary disease (3); peritonitis (1); multiple renal abscesses and uremia (1); uremia (1); and retroperitoneal cellulitis (1). Of the 101 patients (of 110 patients reviewed), who survived cystectomy with or without pelvic gland dissection and uretero-intestinal anastomoses, 40 are living and well (39.6 per cent), and 6 have uremia and metastasis; 4 were lost to follow-up and are presumed dead. The total number of survivors for five or more years is 45.5 per cent (Table 4, on next page).

It is worthy to note, however, that several operations in this series were performed on patients having neoplasms of low-grade malignancy, and neoplastic infiltration had not extended deeply into the muscularis layer of the bladder. Today I would treat such tumors by transurethral resection followed by cobalt-60 teletherapy.

In 1952, at the Ninth Congress of the International Society of Urology in presenting my first series of patients in whom cystectomy and uretero-intestinal anastomosis had been performed for the relief of patients with carcinoma of the bladder, I stated, "at the present time I advocate cystectomy for all grade 2, 3, and 4 infiltrating carcinomas of the bladder and papillary noninfiltrating neoplasms involving the ureteral orifices, which are technically possible to remove by this procedure. The continuance of this type of treatment will be influenced by the end results of a large series of

TABLE 4.—End results of cystectomy for carcinoma of the bladder.*

	Number of patients	Grade of tumor	Last known status
Total .. 1	1	I A_1	Living and well, 6+ years
	5	II A_1	Living and well, 5 to 11 years
Total .. 6	1	II A_1	Died (coronary disease), 7 years
	6	II A_2	Living and well, 7 to 11 years
	3	II A_2	Died (metastasis), 2 to 7 years
	2	II A_2	Died (coronary disease), 1 to 7 years
	2	II A_2	Died (uremia), 3 to 5 years
Total .. 14	1	II A_2	Living (uremia, metastasis), 6+ years
	3	II B	Living and well, 6 to 7 years
	2	II B	Died (metastasis), 2 to 3 years
	2	II B	Cerebral accident, 9 years
	1	II B	Living (uremia, metastasis), 6 years
Total .. 9	1	II B	Lost trace of, 2 years
	3	II C	Living and well, 5 to 6 years
	2	II C	Died (uremia), 1 to 2 years
Total .. 6	1	II C	Living (metastasis), 2 years
None		II D	—
	4	III A_2	Living and well, 5 to 9 years
	2	III A_2	Died (metastasis), 3 to 5 years
	1	III A_2	Died (hypertension), 20 years
	1	III A_2	Died (coronary disease), 3 years
Total .. 9	1	III A_2	Died (influenza), 2 years
	6	III B	Living and well, 2 to 7 years
	3	III B	Died (metastasis), 7 months to 1 year
	2	III B	Died (coronary disease) 1 to 3 years
	1	III B	Died (abscesses—kidneys), 1 year
Total .. 13	1	III B	Died (uremia), 6 years
	3	III C	Living and well, 5 years
	2	III C	Living, 1 to 2 years, lost trace of
	2	III C	Died (metastasis), 2 to 4 years
Total .. 9	2	III C	Died (coronary disease), 1 year
	3	III D	Living and well, 5 to 7 years
	6	III D	Died (metastasis), 8 months to 2 years
Total .. 10	1	III D	Living (uremia, metastasis), 6 years
None		IV A	—
None		IV B	—
	3	IV C	Living and well, 6 to 7 years
	2	IV C	Living (uremia, metastasis), 5 to 6 years
	4	IV C	Died (metastasis), 11 months to 3 years
	1	IV C	Died (uremia), 1 year
Total .. 11	1	IV C	Died (hemiplegia), 1 year
	3	IV D	Living and well, 6 to 7 years
	1	IV D	Living, 5 months, lost trace of
	6	IV D	Died (metastasis), 3 months to 5 years
	1	IV D	Died (uremia, metastasis), 2 years
	1	IV D	Died (uremia), 4 years
Total .. 13	1	IV D	Died (coronary disease), 5 months

Courtesy of American Surgeon, paper in press.

cases observed over a five-to-ten year period." I would like particularly to call attention to that last statement made nine years ago.

Present treatment

In recent years, as time has elapsed permitting an accurate later appraisal of that series and the present series of cases, my initial enthusiasm for cystectomy has waned. The first series was reported during the period of overenthusiasm for radical and supraradical surgery. The end results of more conservative procedures left much to be desired, and perhaps obsessed with the mode of the hour, I felt justified in increasing the magnitude of the operative procedure.

Since the introduction of the recent chemotherapeutic agents, it has been observed that upper urinary tract complications are of less importance than the high incidence of metastasis and death from metastatic disease following cystectomy. This is confirmed by postoperative intravenous urographic studies that reveal normal kidneys and ureters in 41.2 per cent of patients followed over a five-year period. I have a strong conviction that many patients who underwent cystectomy would have lived as long, if not longer, had more conservative surgical procedures been used.

Conclusion

At the present time I am performing fewer and fewer cystectomies for infiltrating carcinoma of the bladder. It is not my desire to imply that cystectomy and uretero-intestinal anastomosis is not a sound surgical procedure in selected cases of carcinoma of the bladder, but overenthusiasm for it will assuredly be followed by disappointment, unless extreme care is exercised in the selection of cases.

There is no single surgical procedure to be advocated in the treatment of patients with carcinoma of the bladder. Individualization of treatment is essential, based on a meticulous observation of facts derived from clinical, laboratory, biologic, and post-mortem data.

Let us then hope we shall select the preferable treatment in the best interests of the patient.

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"DIME" it is

It transpires, quite unexpectedly, that the initials of the new Division of International Medical Education are DIME. In keeping with well established custom, the Division will doubtless become known as DIME. This is accepted in good grace. It is not a bad sobriquet, although the sum suggested might have been a bit handsomer. Through its fresh association, the word DIME can achieve a new and richer meaning. Such has been the fate of the workhorse pronoun, WHO, which has come to have fresh significance in association with the World Health Organization. This alphabetic accident caused some trepidation in 1946, and an attempt was made to sidestep it. The only acceptable alternative, however, to the name World Health Organization turned out to be Health Organization of the World, which produced HOW.

So, DIME it is. *Association of Am. M. Colleges News Letter, July* 1961.

Modern Diagnostics of Peripheral Ischemia

Frank V. Theis, M.D.,* *Chicago*

Physiologic or pathologic reduction of the normal blood flow in the extremities is known as peripheral ischemia. This may vary from a transient and mild grade of local anemia in some cases to a severe grade in others. Most of us have experienced temporary and insignificant episodes of physiologic vasoconstriction of the hands and feet following exposure to cold, fatigue, emotional stress, or toxic effect of tobacco. However, the circulatory disturbance due to pathologic vasospasm or organic arterial occlusion may progress to serious circulatory deficiency and to death of tissues. The presence of ischemia is not difficult to detect, and furthermore, modern diagnostic methods will determine the cause of the reduced blood flow as well as the systemic diseases that are contributing to or are associated with the vascular disease. It is important to evaluate these two factors in order to predict the course of the disease and to select the treatment that will be most effective.

Clinical diagnosis of ischemia

Because the color and temperature of the skin are affected by blood flow, the presence of ischemia is recognized easily by inspection and palpation of the limb. The color of the involved part will vary from pallor or blanching, especially on elevation of the extremity, to cyanosis and deep rubor on dependency, according to the cause and severity of the circulatory deficiency. The skin will be cool or cold; with unilateral involvement as little difference in temperature as two degrees F. can be detected by palpating the contralateral part. The skin in vasospastic disease is usually moist due to simultaneous sympathetic activity of the sweat glands. On the other hand, organic arterial occlusion affects not only the skin but also the blood flow in the muscles and nerves. Muscle cramps or claudication in the legs on exercise with prompt relief on resting, and rest pains in the muscles when the extremity remains horizontal in bed are characteristic features of serious circulatory deficiency. Continuous neuritic type of pain is confined generally to the distribution of a nerve. In vasospastic disease the peripheral arterial pulsations are palpable, while in cases of organic occlusion the pulsations are reduced or absent.

Physiologic and pathologic causes

After the preliminary diagnosis of ischemia has been made, it is necessary to determine the cause of the reduction in circulation. Special tests will demonstrate the presence of (1) arterial and arteriolar spasm, (2) main arterial occlusion, or (3) combined occlusive disease and vasospasm.[1]

Vasospastic peripheral circulatory disease occurs as physiologic or pathologic arteriolar constriction. Exposure to cold, toxic effect of tabacco smoking, emotional or psychic factors, fatigue, endocrine hypofunction, hyper- or hypotension, and severe anemia either pernicious or secondary to chronic blood loss are systemic physiologic causes of bilateral and symmetrical peripheral ischemia. Pathologic vasospasm is observed in Raynaud's disease or Raynaud's phenomenon, peripheral neuritis, scalenus anticus or cervical rib syndrome, painful osteoporosis, paralytic limbs, "dead fingers" or acrocyanosis. In pure vasospastic disease or when adequate collateral circulation compensates for main artery obstruction, vasodilator tests will produce normal skin temperatures. Occasionally, when normal response has not occurred, the tests should be repeated to assure that maximum readings have been obtained (Fig. 1). In neurocirculatory cases peripheral arterial pulsations are palpable.

Organic occlusion of the peripheral arteries occurs in atherosclerosis or arteriosclerosis obliterans, either diabetic or nondiabetic, in presenile atherosclerosis obliterans or Buerger's disease,[2] in arteritis or arterial trauma with thrombosis, and in peripheral embolism. As a rule, the onset and progressive course of the

Presented at the Chicago Medical Society Postgraduate Course on Modern Diagnostics, Oct. 19, 1960.

**From the department of surgery, Presbyterian-St. Luke's and the Cook County hospitals, Chicago.*

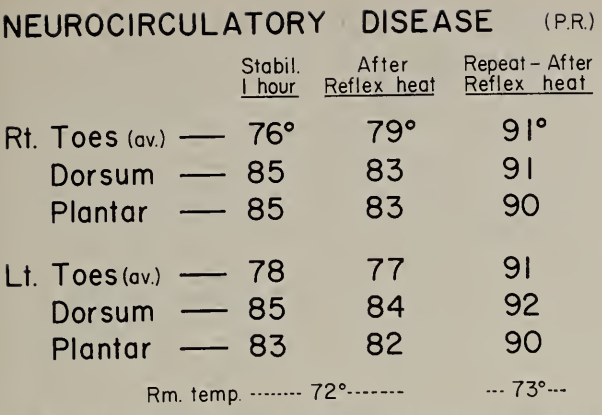


Figure 1. Peripheral skin temperature readings of a patient with neurocirculatory disease. Under standard stabilized conditions the skin temperatures of the feet failed to rise to normal levels after one hour reflex heat to the abdomen. Repeated on another day, the same procedure produced a normal response (90 F. plus). Peripheral arterial pulsations were normal.

ischemia is slow, but when obstruction is due to either thrombosis or embolism the onset may be sudden and acute in 50 per cent of the cases. The severity of the ischemia will depend upon the site, extent, and completeness of the occlusion in the main artery and the adequacy of the collateral channels to compensate for the obstructed vessels. When the main artery obstruction is segmental and limited, the circulation may not be seriously interrupted so that symptoms may be minimum or absent. In these cases, peripheral arterial pulsations and oscillometric readings are reduced or absent.

Spasm of the arteriolar and collateral arterial channels is present to some degree in most cases of main artery occlusion. The amount of vasospasm contributing to the ischemia is determined by the skin-temperature response to vasodilator tests. Elevation of the skin temperatures to normal levels will indicate adequate collateral channels. Also, periodic examinations are advisable, for a drop in readings indicates advance of the occlusive disease, while more normal temperatures are observed as the circulation improves.

Special diagnostic tests

Although many tests have been described for academic study of the peripheral circulation, only a few of these are of clinical value. These few provide accurate information on the cause of the circulatory deficiency; the location, extent, and completeness of the arterial obstruction, and the adequacy of the collateral circulation. The procedures we use routinely are as follows:

Stabilized peripheral skin temperature and vasodilator response. Skin temperatures will be affected by (1) the amount of heat produced by the body, (2) the amount of heat circulated by the blood, (3) the amount of heat dissipated by the body surface, and (4) the degree of sweating. Therefore, a standard procedure is used to study peripheral arteriolar and capillary circulation.

With the patient at bed rest for one hour at ordinary room temperature (72 F. to 80 F.) and covered with one blanket, the skin temperatures are taken by means of an electrothermocouple at symmetrical sites on the extremities. If these are lower than 88 F., vasodilatation is produced by placing an electric pad at medium heat on the abdomen for one hour and the readings repeated (Fig. 2). Originally, for academic studies a temperature-controlled room at 68 F. was used, but we found that room temperatures of

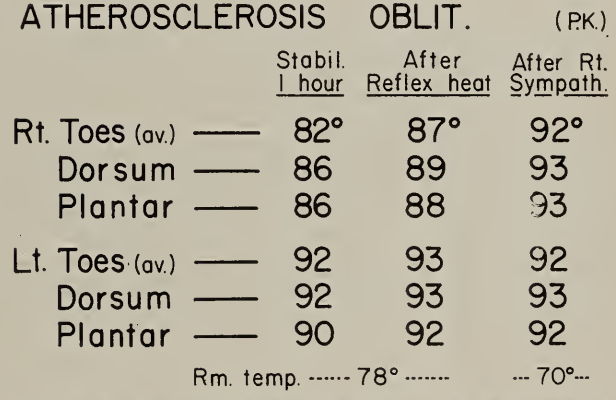


Figure 2. Abnormal skin-temperature responses of a patient with advanced atherosclerosis obliterans of the right lower extremity. Normal readings were obtained on the left side. Repeated readings were unchanged. After right lumbar sympathectomy the skin temperatures returned to normal limits and have remained so for five years. Peripheral arterial pulsations were absent on the right side and present on the left side.

72 F. to 80 F. are more effective in producing maximum vasodilatation. Higher or lower environmental temperatures require special interpretation of the readings. The purely vasospastic ischemic limb will usually react promptly to a colder or to a warmer room temperature, while cases with organic occlusion will respond only to the degree that constriction or dilatation can occur in the collateral vessels.

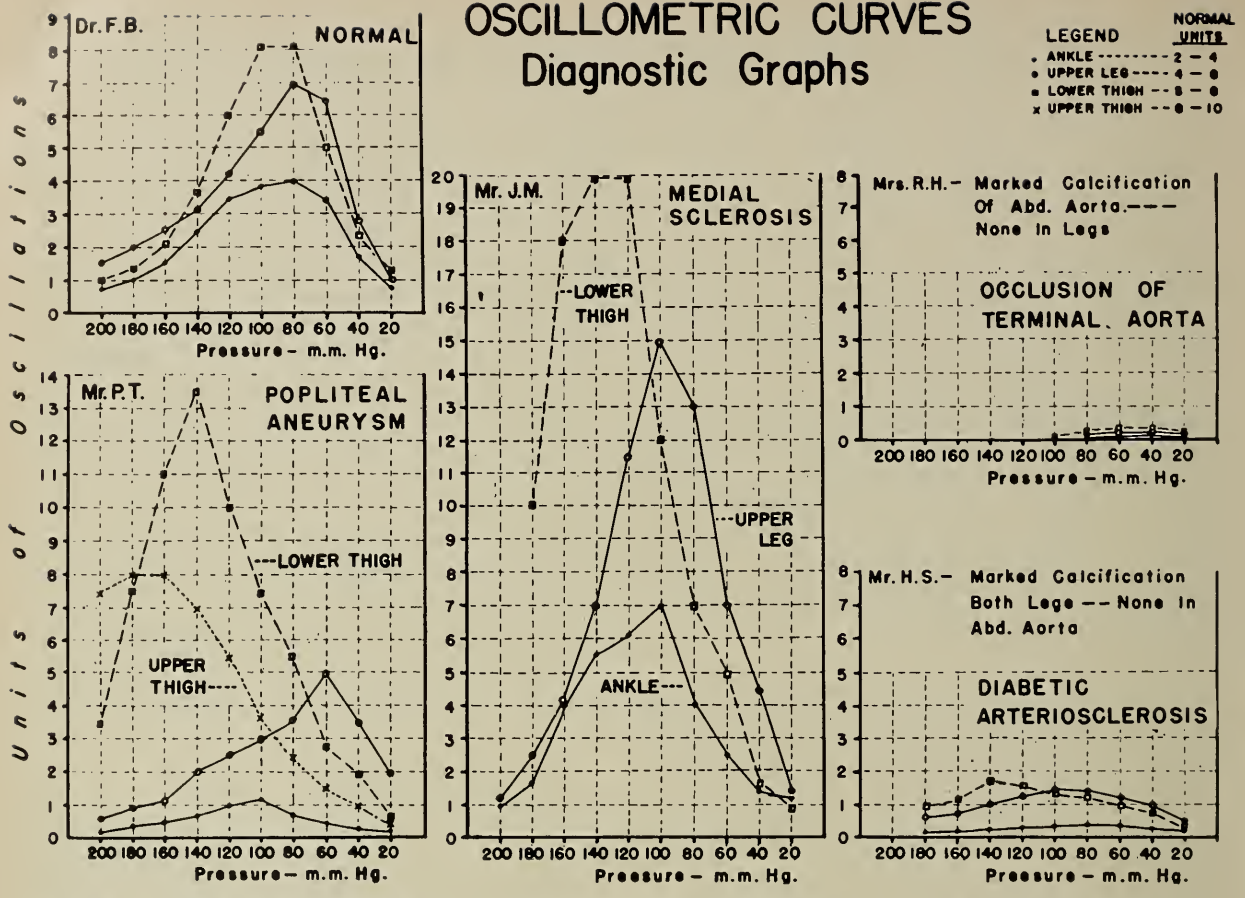


Figure 3. Characteristic features of (1) normal oscillometric readings with increase in the curves from the ankle to the upper thigh; (2) popliteal aneurysms have a markedly elevated curve at the site of the aneurysm and low proximal and distal curves even though the aneurysm may be too small to bulge or to be palpated; (3) medial sclerosis with marked elevation of the curves at all levels on the extremities; (4) occlusion of the terminal aorta, with curves at all levels symmetrically reduced to zero or almost zero and also shifted to the right of the graph; and (5) diabetic arteriosclerosis with marked calcification of the peripheral arteries (curves are all reduced and flattened).

The skin temperature vasodilator test, under standard conditions, provides information on the arteriolar, capillary, and collateral arterial circulation in the extremity. More than 95 per cent of the cases with vasospastic ischemia will have normal vasodilator response with heat to the abdomen so that other methods, such as sympathetic blocks or drugs, have rarely been necessary.

Oscillometric readings provide information as to the patency of the main arteries of the extremities (Fig. 3). When taken with a good oscillometer (Pachon), under standard conditions by an experienced technician, the procedure is a safe, simple, and practical method for determining the site, extent, and completeness of the obstructing lesion. Periodic examinations will show further reduction or disappearance of oscillations as the arterial obstruction progresses, or elevation in the readings as the patency returns. They are taken at symmetrical sites for comparison of the two extremities with normal levels. Elevation of the oscillometric index above normal levels may be present in peripheral arterial aneurysm.[4]

Arteriography. Roentgen visualization by intra-arterial injection of radiopaque material will reveal the condition of the main arteries and the collateral channels. However, this procedure involves the serious risk of (1) systemic or local reaction from the injected material, (2) false visualization of arterial obstruction due to arteriospasm, (3) arterial thrombosis, and (4) severe pain in the limb unless anesthesia is used. As a routine procedure arteriography is inadvisable, but the visualization may be indispensable

when direct arterial surgery is contemplated. However, for indirect surgery such as sympathectomy, oscillometric readings and vasodilator skin-temperature findings will provide sufficient information on the condition of the circulatory channels.

Neurodermometer tests. Vasospastic peripheral ischemia, either primary or associated with organic occlusion, has a variable amount of sweat gland activity.[3] This is due to sympathetic nerve stimulation for both vasoconstriction and hidrosis. By means of a special electroresistant instrument, the neurodermometer, unit readings of skin moisture are obtained. In the absence of vasospasm and sweat gland activity as occurs following sympathetic block or neurectomy, the readings are zero. High readings indicate a high degree of sympathetic activity.

Refilling the peripheral veins. A simple means for detecting the adequacy of the collateral circulation when the main artery is occluded is to observe refilling of the veins of the foot after the limb has been lowered from an elevated position. When only one extremity is involved, the time required is compared with that of the contralateral side. The veins should refill normally within 10 seconds. With advanced circulatory deficiency, one minute or more may be required.

Associated pathologic conditions

After establishing the presence of ischemia and the degree of reduction in blood flow due to the vasoconstriction and/or organic factors, the pathologic conditions that may be contributing to the circulatory disease are investigated.

Blood studies should be made in all cases. Systemic anemia reduces the oxygen-carrying capacity of the circulating blood and will increase the severity of the local anemia due to vasospasm and to occlusive arterial disease. Primary vasoconstriction with symptoms suggestive of peripheral arterial occlusive disease has been observed in pernicious anemia and in secondary anemia following chronic blood loss. Restoring the normal quality of the blood is beneficial in all cases of peripheral ischemia.

Pathologic cholesterol, uric acid, and sugar metabolism are associated with atherosclerosis and arteriosclerosis obliterans. The elevated blood levels of the three metabolites are important indices of the seriousness of the disease. When the cholesterol is above 250 mg./100 ml., the uric acid above 6.0 mg./100 ml., and the sugar above 120 mg./100 ml., arterial disease can be expected to progress. Corrective measures should be taken to reduce the values to normal levels. However, even when the blood sugar level is normal, investigations of postprandial and sugar tolerance may be indicated. Unusual conditions may be present and must be considered. Some patients have a normal fasting blood sugar of 100 mg./100 ml., but this may increase to 250 mg. or higher two hours after eating. Others may have a diabetic glucose tolerance curve without abnormal fasting blood sugar or spilling sugar into the urine. These biochemical blood studies are important in cases of occlusive arterial disease. Unusual blood sugar findings are observed especially in patients with advanced diabetic neuropathy.

Urinalysis for the presence of sugar is the simplest test for detecting most cases of diabetes mellitus. However, many diabetic or potentially diabetic patients may not have sugar in the urine even with high blood sugar levels or diabetic glucose tolerance curves. Therefore, it is best to study abnormal metabolism by blood sugar determinations.

Albuminurea in long-standing cases of diabetes may indicate the presence of Kimmelstiel-Wilson disease.

Thyroid function tests. Hypothyroidism plays an important role in both vasospastic and atherosclerotic disease. Low thyroid function is related to disturbed cholesterol metabolism resulting in hypercholesteremia and to reduction of body heat that will contribute to vasoconstriction. We rely on the protein-bound-iodine determination as the most reliable index of thyroid function.

Electrocardiographic studies. Cardiac insufficiency will contribute to poor blood flow and peripheral ischemia, especially when there is a resulting hypotension. Also, cardiac fibrillation in hyperthyroidism and in rheumatic heart disease is a frequent cause of cardiac insufficiency and of intracardiac thrombosis leading to peripheral emboli. Routine electrocardiographic studies and cardiac evaluation may reveal evidence of coronary occlusion.

X-rays. Arteriosclerosis of the abdominal aorta and peripheral vessels may be found on a plain roentgenogram. The amount of calcification, however, is no criterion of the obstructive process in the arteries; more extensive calcification oc-

curs in medial or Monckeberg's arteriosclerosis, which is not an occlusive disease. Sclerosis of the abdominal aorta may be accompanied by mural thrombi on atherosclerotic plaques and may be the source of peripheral emboli.

Cultures and sensitivity tests. Infection with a symbiosis of infective organisms is frequently a critical factor in ischemic tissues and is usually difficult to control. Failure of infection to respond to therapy is due to severity of the ischemia and presence of resistant symbiotic organisms. Wound cultures and sensitivity tests should be made in order to select appropriate antibiotic therapy.

Conclusion

Modern diagnostics of peripheral ischemia include: (1) establishing clinically that a definite reduction in peripheral blood flow exists, (2) evaluating by special tests the vasoconstrictor and organic occlusive component of the circulatory disturbance, and (3) detecting the associated pathologic conditions that are contributing to the circulatory disease. The information thus obtained will permit selection of the most effective therapeutic measures.

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Nipple discharge

Spontaneous discharge from the nipple occurs in about 5 to 6 per cent of patients with mammary disease. By careful inspection, palpation, and microscopic examination of the discharge it usually can be classified in one of seven different categories, each of which has a different group of etiologic possibilities with appropriately varying treatments. The serous, bloody, and sanguineous and combined serosanguineous types may be considered together, since they have similar causes and call for similar therapy. The vast majority of nipple discharges are due to benign lesions, many of which do not require surgical intervention. The most common types of discharge are the serous and the combined serosanguineous type. When these are combined with the bloody type and the rare watery discharge, they represent the most important types, because, although the great majority are due to benign lesions, especially intradactal papillomas, they may reflect malignant change. Nipple discharge is not common in cases of carcinoma of the breast, averaging only about 2 to 2.5 per cent. When there is a watery, serous, bloody, or combined serosanguineous discharge, however, surgical exploration is mandatory. If a mass is palpable, which is almost always the case with carinoma, a biopsy should be obtained and future therapy guided by the histologic observations. In 25 per cent of the cases in which a tumor cannot be detected, careful palpation of the circumareolar area usually will reveal a pressure point that will localize the appropriate site for surgical exploration and biopsy. *Henry Patrick Leis, Jr., M.D. The Significance and Treatment of Nipple Discharge. J. Internat. Coll. Surgeons. January 1961.*

Clinical-Surgical Conferences



COOK COUNTY HOSPITAL

The Problem of Shock

MODERATOR: ROBERT J. BAKER, M.D.
Associate Director, Department of Surgical Education, Cook County Hospital

DISCUSSANT: WILLIAM SHOEMAKER, M.D.
Assistant Professor of Surgery, Chicago Medical School; Director of Surgical Research, Michael Reese Hospital

DR. ROBERT J. BAKER: Clinical shock is a complex hemodynamic, hematologic, and metabolic change in the body economy with widespread implications in many organ systems. More than that, and from a purely practical standpoint, it is a state calling for immediate, specific, and effective resuscitative measures to these conferences.

The practical considerations in this condition are intermingled with the experimental bases for rational therapy; it is impossible to divorce the laboratory investigation from the bedside treatment, and considerable mystery still surrounds both sides of this difficult problem. As an example, it is not known why patients in shock die, nor why shock becomes irreversible in some patients.

Our guest is a research physiologist, a capable clinical surgeon, and a most articulate speaker; all of these attributes are necessary for the illuminating discussion of this entity that we know will follow. Dr. William Shoemaker is assistant professor of surgery at the Chicago Medical School and director of surgical research at Michael Reese Hospital, a relatively new and extremely fascinating department. His acquisition by Michael Reese has been felt by everyone to be a wonderful step forward from a research and teaching standpoint. We hope to call on his experience frequently in the future and will cover some of the more basic aspects of problems that we do not often have occasion to discuss in these conferences.

Case 1

DR. D. SNYDER, surgical resident: A. D., a 42 year old Negro female, was admitted to the Cook County Hospital with a history of hematemesis and melena for 24 hours. Her husband stated that she had a known duodenal ulcer for seven years, which was ushered in at its onset by a similar episode of hematemesis. She had not adhered to ulcer management, and occasional tarry stools were brought on by drinking bouts.

Physical examination revealed a restless woman whose skin was cool and clammy, and whose mucous membranes and nailbeds were pallid. Her blood pressure was 92/74 mm. Hg, pulse 128 per minute and regular but somewhat faint. She vomited about 200 cc. of clotted dark red blood during this examination. The remainder of the examination was negative except for minimal epigastric tenderness.

Hematocrit was 34 per cent, and radioactive iodinated serum albumin (RISA®) blood volume indicated a deficit of 820 cc., which represented approximately 16 per cent of the expected normal blood volume.

Blood replacement was commenced immediately and, as the patient could not void, 80 cc. of urine was removed from the bladder. Urinalysis was negative, and specific gravity was 1.022.

Dr. Baker: This patient presented as a classical bleeding peptic ulcer with an excellent history, in contrast to our usual case, and good external evidence of visceral bleeding. She was considered to be in hemorrhagic preshock, and it is this aspect of the problem of shock that we would like to have Dr. Shoemaker discuss.

Dr. William Shoemaker: First I should like to express my appreciation for being asked to discuss this problem. It is indeed an honor and pleasure to be here.

This case represents a type of patient frequently seen on the wards. The problem is that of a single acute hemorrhagic episode. The patient is not in frank peripheral vascular collapse or shock. With loss of 15 to 25 per cent of the blood volume, the patient must be considered in preshock, if not actual shock. Furthermore, distinctions must be made between a single acute hemorrhage and gradual but massive blood loss. There are marked differences both qualitative and quantitative between the reactions of shock and preshock as well as the differences between a single hemorrhage and gradual prolonged hemorrhage.

If approximately 20 percent of the blood volume is suddenly withdrawn, the effects on the circulatory tree are more pronounced than the metabolic and functional effects on the vital organs. At this stage the disorder is primarily one involving the heart and great vessels. It is, as in this case, a problem of sudden blood loss and blood replacement. With transfusion of an amount equivalent to the blood loss, prognosis should be favorable, provided no further blood loss occurs.

The signs and symptoms of this condition are decreased blood pressure, decreased pulse pressure, increased pulse, sweating, pallor, weakness, dizziness, and eventually, decreased hematocrit. The most important clinical or laboratory findings are not the hematocrit nor blood pressure. The most important single determination, in my opinion, is the blood volume. There is nothing quite so good for measurement of blood loss as the measurement of blood volume. The other measurements (hematocrit, blood pressure, pulse, etc.) are indirect reflections of blood volume deficit and are subject to considerable variation.

The hematocrit is a frequently misinterpreted test. A fall in the hematocrit from blood loss is not a direct effect of hemorrhage but rather a secondary, or compensatory, reaction. It indicates the amount of capillary refilling from extracellular fluid. The addition of this extracellular fluid to the intravascular space decreases the *percentage* of red cells in the circulating blood. It takes 6 to 12 hours for a pronounced fall in the hematocrit to occur. With sudden massive hemorrhage, as in arterial lacerations, complete exsanguination may occur without appreciable change in hematocrit. By contrast, the patient who bleeds slowly will have time to develop a decreased or falling hematocrit. This test is of value in the initial period of hemorrhage only when there is a relatively slow rate of loss of blood. After multiple transfusions and intravenous fluids, hematocrit determinations are virtually meaningless.

The next most important sign is decreased or decreasing pulse pressure. Frequently, blood pressure may be difficult to evaluate and interpret. A decreasing pulse pressure, however, is a more sensitive and reliable indication of circulatory failure.

Dr. Baker: How valuable are blood volume measurements in patients in frank clinical shock?

Dr. Shoemaker: We have studied blood loss and blood volume, both clinically and experimentally. Blood volume measurements in shock, if properly performed and interpreted, are extremely useful.

Dr. Baker: How about the patient with ascites?

Dr. Shoemaker: I think this determination is reliable in the patient with ascites, provided it is properly performed. A single measurement 10 minutes after injection of the dye will not accurately measure plasma volume. Several de-

terminations taken over a 30 to 60 minute period and extrapolated back to the time of injection (zero time) will provide the plasma concentration necessary for proper application of the dilution formula. This method will be valid in patients with ascites, burns, and "third space" fluid accumulation.

Dr. Baker: How about urine volume and specific gravity? Does this give you any idea of the presence of shock?

Dr. Shoemaker: Almost everyone is alert to the importance of hourly urine volume and urine specific gravity in burns, but there are few who take advantage of this simple but extremely useful measurement in cases of hemorrhagic shock. There is one major difficulty with this measurement. The patient who is in shock may not have normal renal function. As a matter of fact, one cannot even presume a normal, pre-existing renal function in many of these cases. The measurements of hourly urine volume output, therefore, must be carefully interpreted. Nevertheless, changes in the rate of urine output are a sensitive indicator of the circulatory status.

Dr. Baker: What about the 80 cc. here with the specific gravity of 1.022? Do you relate specific gravity to volume?

Dr. Shoemaker: The measurement we would like to have is not the 80 cc. in the bladder but the *hourly volume.* It would be helpful to know how long it had been since she had last voided.

It must be clearly stated that any measurement, including blood volume, used to evaluate obscure or hidden bleeding is valid only for the exact moment it was taken. Obviously, a relatively normal value does not mean that the patient will not bleed again a few minutes later. Measurements only reflect the status at the particular time they were performed.

Dr. Baker: This patient apparently stopped bleeding. No bile was obtained from the Levine tube, but the blood cleared from the drainage, although some faintly brown material was aspirated. She was given two pints of blood. Her blood pressure rose to 100/70 mm. Hg, and the pulse rate dropped to 108 per minute. Would this pulse rate rather than the blood pressure indicate she was out of shock and stable? Her skin was now warm and dry. She had no pain. Do you transfuse such a patient further?

Dr. Shoemaker: By the criteria of blood pressure and pulse, she has improved. The question now is Should one continue further with resuscitative therapy? If these signs are maintained and she continues to improve, we would withhold further blood transfusions and give her other fluids. I don't think that you ever feel safe with a patient who has a known duodenal ulcer. I cannot say that it would be harmful to administer more blood, but in this situation I would prefer not to unless something else happened.

Dr. Baker: She was given the two pints because of measured blood volume deficit. Is this logical?

Dr. Shoemaker: Do you mean are blood volume measurements accurate?

Dr. Baker: Can you interpret such measurements literally? She had an 800 cc. deficit and hence was given two pints of blood. Is it possible to utilize the determination in so precise a fashion?

Dr. Shoemaker: A properly performed measurement of blood volume by RISA is accurate within 5 to 10 percent. The variations of blood volume in people are fairly well known. A healthy normal male will have a blood volume of approximately 8 per cent, whereas an obese female will have less than 7 per cent of her body weight as whole blood. With these qualifications (i.e., variations in the "normal" range with body types, gender, etc., and the possibility of further obscure bleeding *after* the measurement), I would say that properly performed blood volume measurements are as accurate, if not more accurate, than any other measurement of blood volume deficit.

Dr. Baker: This patient did well following the treatment outlined until about 3 a.m. when she commenced to rebleed. The intern called arrived promptly and found her in profound shock without pulse or blood pressure. Would you perform a blood volume determination at this time?

Dr. Shoemaker: If she is in profound shock without blood pressure, you must do what your clinical judgment tells you to do, that is, transfuse her immediately.

Dr. Baker: How much blood would you give and how fast?

Dr. Shoemaker: Give 1000 cc. as fast as you can.

Dr. Baker: If at the end of 1000 cc. her blood pressure is 50/0 mm. Hg, and the pulse rate is very fast, what then?

Dr. Shoemaker: Then give her more transfusions. To give less than 1000 cc. initially, under these circumstances, is unwise.

Dr. Baker: Can you pour blood in so fast that you overtransfuse?

Dr. Shoemaker: Yes. Overenthusiastic therapy is always possible. It is difficult to evaluate precisely the patient who is actively bleeding and who is also being transfused. One of the best measurements of overtransfusion is central venous pressure. This is relatively easy to determine. An extra long (12 inch) polyethylene catheter is placed in a vein in the upper arm so that the tip extends down into the superior vena cava about the level of the right atrium. A reasonably reliable measurement of the central venous pressure will be obtained by connecting this cutdown catheter to a spinal manometer. If blood is given at a rate that the heart can handle, then the central venous pressure will remain below 10 cm. of water. With overtransfusion the central venous pressure will rise abruptly.

There is also an easier, but somewhat less reliable, way to obtain venous pressure. If a bottle of intravenous fluid is allowed to run through an ordinary cutdown until it is empty, then the level of the meniscus of the fluid in the tubing will give the venous pressure of that extremity. It must be remembered that the central venous pressure reflects the venous system as a whole, whereas the venous pressure in the arm reflects only the circulation of that extremity.

Dr. Harold B. Haley, associate attending surgeon: If you are recording vital signs at periodic intervals, is a widening pulse pressure a gauge of overtransfusion?

Dr. Shoemaker: Yes, it may be.

Dr. Baker: This patient was further transfused, and her blood pressure did not rise rapidly enough for the house staff, so she was started on norepinephrine (Levophed®), after which her blood pressure rose, but the urine output dropped. Would you have expected this, and would you use vasopressors in such a patient? Let us assume that her pulse is still rapid and the peripheral vital signs have not improved. Would you use vasopressors with adequate blood replacement?

Dr. Shoemaker: Only as a last resort. I have definite reservations about the use of vasoconstrictors. It is not easy to withhold them; it is much easier to give vasoconstrictors to increase the blood pressure. After this has been effected, and the apparent improvement is impressive, there is a temptation to say that everything was done that could be done. Whether or not increasing the blood pressure actually has anything to do with alleviation of hemorrhagic shock is still controversial. The aim of shock therapy should not be to restore blood pressure. Rather, the aim of shock therapy should be to restore blood flow or perfusion through the tissues, especially to vital organs.

The patient suffering from hemorrhagic shock already has maximal stimulation of epinephrine and norepinephrine secretion. Walker has measured the rate of epinephrine and norepinephrine output after hemorrhage. It is not just a small increase of epinephrine but rather 30 to 60 times the normal resting values after removal of one third of the blood volume. It seem illogical, therefore, to add vasopressors in a situation where the adrenal is already maximally stimulated.

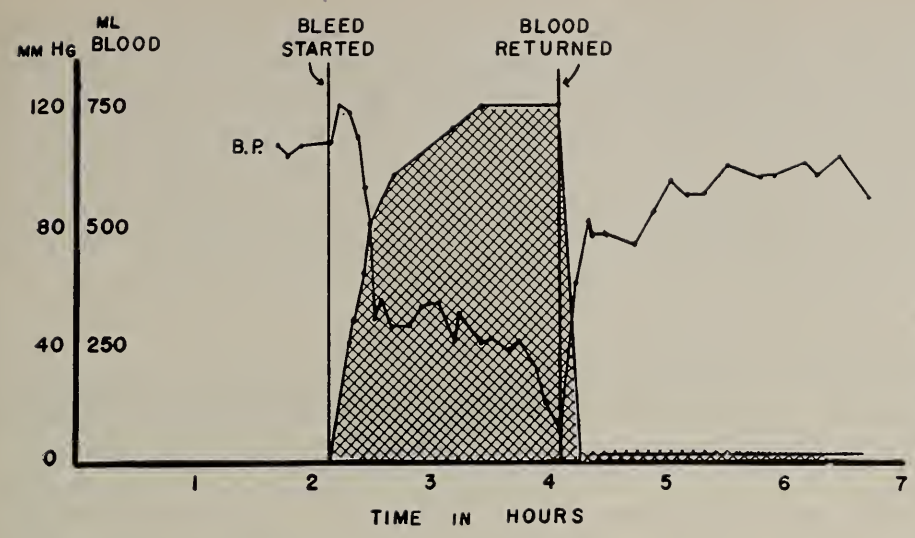
Dr. Baker: Would you treat this patient with steroids?

Dr. Shoemaker: There has been some evidence that under certain conditions hydrocortisone may have a beneficial influence. If adrenal insufficiency is suspected or diagnosed, hydrocortisone may be indicated. However, in the average case of hemorrhage either no improvement or only transitory improvement is seen with hydrocortisone administration.

Most of the work on shock from our laboratory has been done in an effort to describe the basic pathophysiologic mechanisms involved in the development of the shock syndrome.[2]

Fine and his associates[3] described the liver as the site of the primary defect of shock. We have been studying hepatic hemodynamic and metabolic events in order to describe and understand the sequence of events that may lead to the development of the shock state.

Figure 1 illustrates the manner in which hemorrhagic shock is induced. This is essentially the Wiggers, or Western Reserve, technique[4]



Volume of Bleed and Blood Pressure with Hemorrhage and Transfusion

Figure 1. Effect of sudden or "acute" hemorrhage by Wiggers technique. The volume of blood indicated by cross-hatched area is shown in a representative dog together with the mean blood pressure. By permission of Surgery, Gynecology & Obstetrics

for standardized production of experimental hemorrhagic shock.

Figure 2 illustrates measurements of pressure in the portal vein, hepatic vein, and vena cava (central venous pressure). The pressure difference between hepatic and portal vein represents the venous pressure gradient across the liver. On replacement of blood there is a marked rise in the portal vein pressure. Not only is the pressure greater in the portal vein but the difference between hepatic and portal vein pressure is also quite marked after retransfusion.

Figure 3 illustrates the measurement of blood flow through the liver, and calculated hepatic venous resistance. After bleeding, there is increased resistance, and after transfusion of the shed blood there is an even greater resistance. This is the basis of the physiologic dam effect that results in the pooling of blood in the splanchnic area.

The Wiggers method of blood removal and replacement has long been regarded as standard for investigation of shock. We have compared this method of producing shock with gradual prolonged hemorrhage, such as may occur in many clinical situations. We have found

Portal Venous, Hepatic Venous and Central Venous Pressure with Hemorrhage and Transfusion

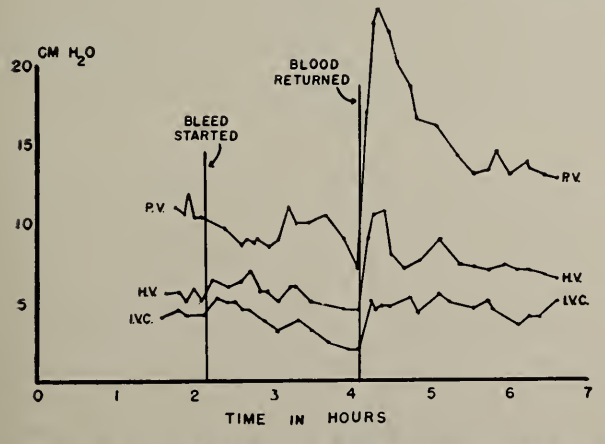


Figure 2. The effect of sudden hemorrhage on portal venous, hepatic venous, and inferior vena cava (central venous) pressure in the same dog as figure 1. After transfusion of the shed blood, a marked rise in portal venous pressure was observed. By permission of Surgery, Gynecology & Obstetrics

Hepatic Blood Flow and Hepatic Venous Resistance with Hemorrhage and Transfusion

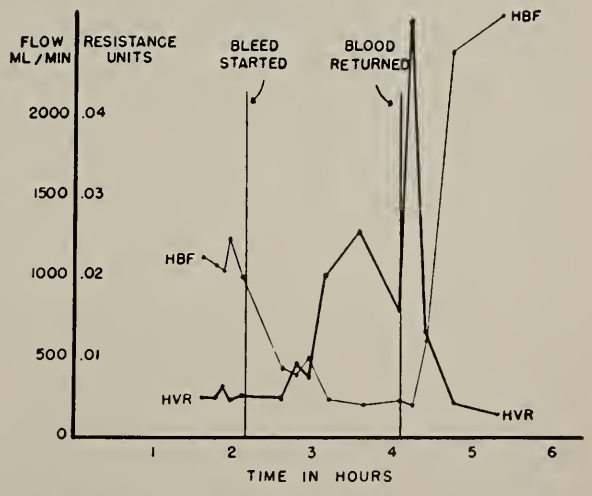


Figure 3. The effect of sudden hemorrhage on hepatic blood flow and hepatic venous resistance in the same dog shown in figure 1. There is a fall in hepatic blood flow and a rise in hepatic venous resistance with this type of hemorrhage. After transfusion of all or nearly all of the shed blood, a further increase in hepatic venous resistance was observed. By permission of Surgery, Gynecology & Obstetrics

by conducting experimcnts of this type that there is a slow fall in hematocrit. When 10 to 20 per cent of blood volume has been removed, there is a marked incrcase in flow across the liver. This is followed by decreased hepatic blood flow in the later stages of shock. We find that events after gradual, prolonged hemorrhage are quite different from those of the sudden, severe hemorrhage of the Wiggers method.

We have measured rates of hepatic metabolism of glucose and some of the body electrolytes. We have also observed the effect of epinephrine under comparable conditions. Plasma potassium is known to be elevated in hemorrhage. This potassium effect can also be produced with very small doses of epinephrine.

In our research laboratory we have conducted a series of 130 experiments on the effects of catechols, epinephrine, and norepinephrine on regional hepatic hemodynamics and metabolism. In these experiments epinephrine was injected into the femoral vein and caused increased arterial blood pressure and portal vein pressure, little change in the hepatic vein pressure, and a markedly increased venous pressure gradient across the liver. There is an increased hepatic blood flow with systemically administered epinephrine. Calculation of the hepatic venous resistance shows a relatively small and unimpressive increase. If the same hormone is injected directly into the liver via the portal vein, then its effect on hepatic hemodynamics may be differentiated from those on the central circulatory system, that is, the heart and great vessels. With intraportal injection the effects on blood pressure are minimal, but the increased portal venous pressure is much more pronounced and lasts longer, as does the pressure gradient across the liver. There is no great change in hepatic blood flow, but the resistance to flow across the liver markedly increases with intraportal epinephrine.

On the other hand, norepinephrine causes a decrease in hepatic blood flow. With norepinephrine the pressure changes across the liver are also different with injection directly into the liver as contrasted with administration into the vena cava. It produces such pressure alterations that there is increased hepatic venous resistance. Thus, resistance is greater after injection into the portal vein as compared with systemic injections.

The metabolic and hemodynamic effects of hemorrhage are in part explained on the basis of epinephrine action. The increased resistance or physiologic damming effect at the level of the outlet hepatic sinusoids presages the pooling of blood or sequestration in the splanchnic area. This phenomenon of sequestration is indicated by a failure of injected, labeled red cells to achieve mixing or equilibration (Fig. 4).

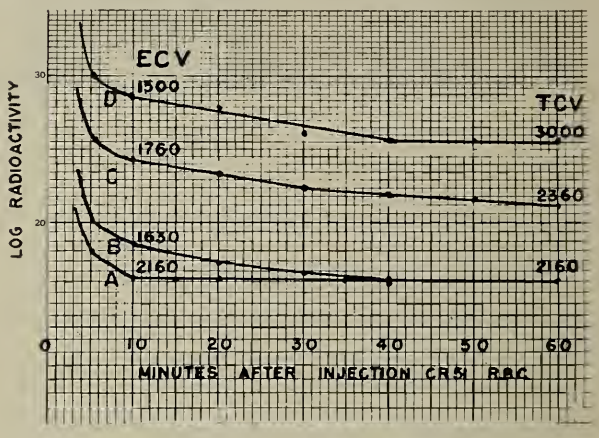


Figure 4. Equilibration curves of Cr^{51} labeled red cells in an animal before and after hemorrhage with transfusion. CURVE A. Control period. Mixing is complete at 10 minutes and no further mixing (indicated by constant radioactivity) occurs during the following hour. The volume of distribution of the label at 10 minutes is identical with the volume of distribution at 1 hour. (2160 ml.) CURVE B. After hemorrhage and transfusion of the shed blood. Equilibration occurs in 40 minutes instead of 10 minutes. The 10 minute volume of distribution of the label is now somewhat less than the final volume of distribution. CURVE C and D. After additional transfusions these curves show a rather small 10 minute volume of distribution compared with the 1 hour volume of distribution.

The rate of equilibration is markedly reduced in the shocked state. In the first curve, after injection of red cells that were labeled with a radioistotpe, we find that we get this equilibration in 10 minutes, and the level of radioactivity is maintained. In the second curve the animal had been put into shock, and its shed blood was returned. Equilibration or mixing requires a longer time. Further additions of blood will increase the total circulating blood volume, but the time that it takes to mix is also increased. Although there are 3000 cc. in the experiment illustrated in figure 4, only half of that is cir-

culating fast enough or effectively enough to be mixed with the injected material within 10 minutes. This lack of effective circulating volume is thought to be the main problem in the patient in shock. If this effective circulating volume is the defect of hemorrhagic shock, then we have a direct measurement of it.

I have attempted to relate the manner in which the various physiologic events conspire to produce this complex picture called shock by describing a vicious circle. Hemorrhage produces decreased blood volume which in turn stimulates epinephrine and norepinephrine release from the adrenal gland. Epinephrine then causes increased hepatic blood flow and increased hepatic venous resistance. I think this hepatic resistance may be compared to Boulder Dam and the sequestration of blood in the splanchnic area to Lake Mead, which builds up behind the dam. This physiologic dam is at the level of the outlet sinusoid of the liver, and red cell aggregation or pooling of blood first occurs behind these outlet sinusoids. Then there is dilatation of the hepatic sinusoids and congestion of the liver. The liver of the dog becomes markedly distended and engorged, but the swelling of the human liver is less impressive. There is a repetition of this microcirculatory defect in the splanchnic area. This leads to lack of effective circulating volume. The latter again leads to increased catechol secretion by the adrenal gland which in turn goes on to give what we like to term the vicious circle of shock. It begins with hemorrhage as the primary initiating cause or defect, but the end result of blood loss is a very complex biologic picture.

This pattern of events is largely the result of neuroendocrine responses that are initially compensatory responses. But when these are stimulated beyond a certain point, they compromise or jeopardize the patient's survival. There is, therefore, a time when epinephrine or norepinephrine will be life-saving. There is also a time when the patient already has too much of these compounds and exogenous administration of more may be definitely contraindicated.

This whole process may be likened to the tire "blowout" that caused an accident. The primary defect was the blowout, but the accident that followed cannot be alleviated by replacement of the tire. In shock, the bodily reactions compound the problem so that an extremely complex situation results. The simple replacement of blood volume is not the whole solution to the problem.

Dr. Baker: How can you tell when norepinephrine would be beneficial and when it would be detrimental?

Dr. Shoemaker: It is my opinion that if vasoconstrictive agents are to be used at all, they should be employed (1) after blood volume has been corrected, (2) as a last resort when other measures have been exhausted or ineffective, or (3) as a temporary measure only under extreme circumstances while the hemorrhage is being corrected. In the Korean War patients received 20 or more pints of blood *after* bleeding had been stopped. Where did it all go? It is our feeling that this excess volume is sequestered in the splanchnic and hepatic areas. Large pools of aggregated red cells are observed microscopically in the liver and other viscera.

Dr. Baker: This is the "taking-up" phenomenon of Moore, which we see so commonly in massive trauma or major vascular surgery.

Case 2

Dr. Baker: F. H., a 20 year old Negro male, was admitted to the medical service of Cook County Hospital with a six-day history of cough, fever, nausea, vomiting, and generalized abdominal pain. His past history was not contributory, although one examiner did get a history of several previous mild attacks of right lower quadrant abdominal tenderness.

Physical examination of this acutely ill patient revealed moderate dehydration, some rhonchi in both lung fields, and diffuse abdominal tenderness, more marked on the right with moderate rebound tenderness. Bowel sounds were absent. Rectal examination disclosed marked tenderness on the right.

Emergency plain films of the abdomen and chest revealed mild bronchopneumonia bilaterally and some evidence of ileus. A surgical consultant requested transfer, and after plasma and fluids, exploration revealed gangrenous appendicitis with diffuse peritonitis. Appenctomy was performed and, after a very stormy postoperative course punctuated by the appearance first of a pelvic and then a right subhepatic abscess, the patient commenced a somewhat downhill course. Nine days after the initial surgical procedure

his temperature was 104.2 F. rectally, pulse 132, blood pressure 76/50 mm. Hg, and his skin was dry. No urine output was recorded for the preceding six hours.

Dr. Shoemaker, would you contrast for us your concept of what happened to this patient and the one with hemorrhagic shock? The end results are similar, but the initiating causes are different.

Dr. Shoemaker: The second case illustrates the problem of septic shock. Although it is true that the initiating causes are different, it is entirely possible that the sequence of events and the pathophysiologic mechanisms leading to shock in this patient have many similarities.

"Shock" is a wastebasket term, a syndrome. It has no real meaning as such. It may be induced by a wide range of agents from trauma to metabolic poisons such as fluoroacetate. If you accept the definition of shock as "peripheral vascular collapse," then any patient who dies does so in shock because his blood pressure drops to zero and his heart stops. Obviously this definition does not help much, but it does illustrate that shock is a very loose and misunderstood term.

Question: Have you done these pressure, flow, and resistance studies across the liver in experimental endotoxic or septic shock?

Dr. Shoemaker: No. We have not yet completed our studies of the effects of hemorrhage, much less of other causes of shock. We do feel, however, that many of the physiologic events or pathophysiologic mechanisms may be common to both disorders. It may be that there is a large element of bacterial toxin in the ordinary variety of clinical hemorrhagic shock.

Question: Is it uncommon for a patient with peritonitis to have decreased blood volume?

Dr. Shoemaker: No. Furthermore, if you transfuse such a patient in septic shock, he still may be in shock but have a normal blood volume. After adequate transfusion the shock is no longer hypovolemic shock but normovolemic shock. Yet frequently the patient may still be in profound shock. As an explanation of these phenomena, physiologists refer to the defect of normovolemic shock as lack of effective circulating volume.

Dr. Baker: How would you handle this patient with septic shock? He had a coliform peritonitis with abcesses and had had several antibiotics.

Dr. Shoemaker: I do not criticize what you have done. I would have nothing to add except to underline that this type of gram-negative bacillus is notorious for producing shock. It may occur without any elevation of temperature. When this is first suspected, blood cultures should be obtained and treatment with specific antibiotics begun.

Dr. Baker: Does norepinephrine help here?

Dr. Shoemaker: This is the place where it would certainly be more appropriate than in hemorrhagic shock.

Dr. Baker: I would like to summarize the final events of both of these cases. In the first case exsanguination from a branch of the left gastric artery was the cause of her continued shock. The second patient succumbed with diffuse abscesses throughout the abdomen and between loops of bowel, and a coliform abscess of the left lower lobe of the lung.

Dr. Samuel Hyman: What about the pulse pressure, which is important in the clinical diagnosis of shock, and the relationship between pulse pressure and central venous pressure?

Dr. Shoemaker: More important than the actual value itself is whether there is a progressive change. Any of these physiologic observations is relative only to the point of time at which it was taken. In cases of clinical shock many measurements will be monitored. But the trend toward an increasing or decreasing pulse pressure is more significant than any given figure.

Summary and conclusions—surgical shock

1. The definition of shock is not based on an absolute blood pressure level, state of skin temperature, etc., but is that state in which the circulatory tree is not able to maintain perfusion of vital organs at an essential rate.
2. The vital organs, in order of decreasing importance are
   (a) Heart
   (b) Brain
   (c) Liver
   (d) Kidney

   The kidney, being lowest in this order, is the first of the vital organs to compensate for the disparity between circulatory tree capacity and circulating volume by renal arteriolar

vasoconstriction. The consequence of this vasoconstriction and one of the hallmarks of uncompensated shock is decreased urine output.

3. An older theory of homeostasis revolved about the liver and kidney:

$$\begin{aligned} \text{Liver} &\rightarrow \text{V.D.M.} \rightarrow \downarrow \text{BP} \\ \text{Kidney} &\rightarrow \text{V.E.M.} \rightarrow \uparrow \text{BP} \end{aligned}$$

Whether the humoral substances, vasodepressor material (V.D.M.) and vaso-excitatory material (V.E.M.), are really produced in anoxia of these two organs is not well established. However, an anoxic liver is detrimental to recovery from shock.

4. Classification of surgical shock includes the following catagories:
   (a) Hemorrhagic
   (b) Neurogenic or traumatic
   (c) Septic
   (d) Drug (central or peripheral)
5. In the management of hemorrhagic shock, it is sometimes necessary to infuse considerably more blood than has been shed to maintain the integrity of the cardiovascular tree. This is referred to as the "taking-up" phenomenon and is as yet not completely explained in the human.
6. The effects of shock on the cardiovascular system are
   (a) Arteriolar vasoconstriction
   (b) Decreased systolic BP
   (c) Decreased venous return (to the right heart)
   (d) Tachycardia
   (e) Decreased cardiac output
   (f) Lessened coronary perfusion
7. Postoperative shock is a difficult state to assess and, hence, to treat properly. The most likely causes are
   (a) Inadequate blood replacement during surgery
   (b) Inadequate hemostasis with postoperative bleeding.
   (c) Hemolytic transfusion reactions
8. A *rare* cause of postoperative shock is acute adrenal insufficiency. The characteristics of acute postoperative addisonism are
   (a) Hyperpyrexia
   (b) Hypotension
   (c) Irrationality, stupor, coma

   Treatment of postoperative shock with steroids is usually unrewarding but in certain states should be used, though the treatment is empiric.
9. *Shock is never termed "irreversible" until the patient has died.*

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Reactions to light

Phototoxic reactions are characterized by an intensification of the normal sunburn response, and are dependent upon the presence in the skin of a "photosensitizing agent." In the past few years, there has been an increased incidence of this type of exaggerated sunburn reaction.This has been seen particularly in patients taking certain drugs, notably some of the tranquilizers, broad-spectrum antibiotics, sulfonamides, and newer diuretic agents. Externally applied substances such as coal tars, various dyes, and perfumes containing oil of Bergamot can also produce phototoxic reactions. *Edwin J. Levy, M.D. Sunlight Sensitivity. Consultant. June 1961.*

The View Box

Franz Gampl, M.D., *Chicago*

The patient, a 9 year old Negro boy, was admitted with the clinical diagnosis of intermittent bowel obstruction. He gave the history of episodes of colicky pain in the midabdomen. These pains were unrelated to meals, but were usually associated with or elicted by a bowel movement. Although he was always constipated, the symptoms became more severe in the last few weeks. There was no blood or mucus in the stools, which were of normal consistency. A rectal biopsy for similar complaints was done elsewhere and was diagnosed as aganglionosis of the rectum.

The physical examination revealed a well nourished boy with moderate abdominal distress. The blood pressure, pulse, and respiration were normal. The abdomen was distended, and there were hyperactive bowel sounds. An ill-defined mass was palpated in the right lower quadrant of the abdomen. The rectal examination was negative. The blood count and differential count were normal. For further evaluation of the child's obstructive symptoms a barium examination of the colon was ordered.



Figure 1. Postevacuation study of the colon.

What is your diagnosis?

Ulcerative colitis
Aganglionosis of the colon
Ascariasis, normal large bowel
Large bowel obstruction

(*continued on page* 153)

From the radiology department, Cook County Hospital

A fat boy always remains a fat boy

The most striking finding to emerge from this study is the remarkable difference between men who have been obese all their lives and those who became obese when adult, a difference most evident in their psychologic problems, but in no case did these problems seem influenced by their obesity. For example, not one of 14 adult obese subjects revealed any disturbance in his concept of his body. By contrast, the obesity of six of 11 "juvenile obese" subjects colored their concepts of themselves and their bodies in a most derogatory manner. *M. Mendelson, M.D., N. Weinberg, Ph.D., and A. G. Stunkard, M.D. Obesity in Men: A Clinical Study of Twenty-five Cases. Ann. Int. Med. April 1961.*

MEDICINE IN THE OUT-OF-DOORS

Hearts of Hunters

JULIUS M. KOWALSKI, M.D., *Princeton*

THE ONLY BIG GAME hunting that hundreds of thousands of able-bodied men do and ever will participate in, and some women too, is the quest of the White-tailed Deer. Under efficient game management this species has increased to the point of becoming a hazard to motorists in some suburban areas, and counties now are open that have not had a deer season for 50 years or longer. With the exodus to the woods in late fall there inevitably follow the headlines: *Ten Hunters Die from Heart Attacks in Week.*

Such startling statements are indisputable. Their ominous portent warrants further inquiry, because from statistical methods it is possible to derive ridiculous conclusions.

If a man garbed in hunting clothes while driving to or from a deer habitat succumbs to a heart attack, he is considered by the press as a "hunter death." The same man on another day traveling the same route as a salesman and afflicted in like manner would be reported as an "unfortunate death." Surprisingly enough, 26 per cent of heart attacks occur during mild physical activity such as driving a car or normal housework.

If the hunter stopped at a motel enroute and expired during the night, he would be among the ten hunter deaths reported for that week. But evidence supports the fact that 23 per cent of coronaries occur during sleep, and 40 per cent occur from 9 p.m. to 6 a.m. when the average hunter is engaged in nothing more strenuous than holding four aces or bending an elbow. Rest, the panacea for all ills, is exactly what 27 per cent of patients were engaged in when they got their heart attacks. If our hunter was sitting quietly on a stump near a runway and his atheromatous plaques of long standing suddenly occluded a coronary vessel, he too would be among the maligned. From the foregoing we deduce that three fourths of all coronaries occur while the patient is asleep, resting, or engaged in mild activity!

But what about the Herculean efforts of the hunt during inclement weather? The slogging through marsh, over hills, the battle through brambles which leave one bowed, breathless, and fatigued; the jangling of adrenals with every questionable moving shadow and snap of twig? Alas, only 2 per cent (*sic*) of heart attacks are accompanied by severe physical activity. And moderate activity as performed in the building trades was the effort expended when 10 per cent of the patients were struck. The inoccuous automatic activity of walking was the pursuit of 13 per cent of heart attack cases.

To gather for several days to a few weeks 100,000 men whose ages range for the most part from the late 30's through 60's clad in red or yellow with firearms in hand, and extrapolate this figure into a recognizable community, it then becomes a city of at least half a million inhabitants. Coronary deaths occur in such communities with methodic frequency each week of the year, and there is no public cognizance of this except for an occasional outstanding citizen. But the autumnal headlines will have their day.

Cardiac emergencies arise in the field as well as elsewhere, but their diagnosis and treatment are more difficult at certain times. Often a seemingly healthy patient asks his physician for a few simple rules by which he could recognize a coronary in himself or his hunting companions. He knows of the pain and radiation in the left shoulder and arm. He knows too that what often appears to be a gastrointestinal upset may be more serious that that. Deep boring, unremitting pain substernally persisting for hours indicates to him a grave condition. These findings associated with palor, sweating, and uneasiness indi-

cate the onset of shock, especially if the pulse becomes rapid and thready.

It is mandatory now for the afflicted to remain at rest, being made as comfortable as conditions permit. Above all, he must be kept warm. To walk for aid or exert any physical effort with such findings is to trudge to almost certain death. The Finnish lumberjacks, rugged woodsmen that they are, were recently studied in this respect, and the deaths or serious complications were in direct relationship to the activity expended, as in walking, after the onset of coronary symptoms. Witness too the number of silent coronaries found by ECG or autopsy examinations. The patient's past history after careful interrogation may reveal that persistent neuritis in the left arm and hand years ago; or an upset stomach that lasted about a week; perhaps that painful pluerisy in the middle of the chest long ago could be the clue. Yet these patients remained at rest for a number of days or weeks, had no doctor, and probably used some nonspecific home remedies, and eventually recovered from their attacks.

In the field when a coronary is suspected, the prime consideration is to combat shock. Absolute rest is imperative. Move the patient only if this can be done by litter and with no physical expenditure on his part. Aid must be sought with dispatch. If the distances are great, medical aid and appropriate transportation must be brought to the suspect.

In every deer hunting area there lives the almost legendary septogenarian who has put venison on the table for many years. He no longer joins in the drive across the lower 40 but sits quietly upon a stump. And there he probably will die.

Personal injury claims

There appears to be a new specialty in the practice of law—the prosecution of personal injury claims. According to a recent article in Harper's Magazine, this type of legal work now takes up three-fourths of the time of the civil courts as contrasted with 5 per cent of the time in the courts of England. However, in England the case load is increasing also. The large number of automobile accidents accounts in part for the avalanche of claims in court. But there is sometimes something screwy about these claims. In Boston a truck was run into by a streetcar. The capacity of the streetcar was 68 passengers, but 240 claims resulted from the accident. Even the sidewalk observer may now establish a claim. A woman witnessed an automobile accident and shortly miscarried. She filed suit against one of the drivers and collected $90,000. There is a large volume of medical malpractice suits in court and it is estimated that at any one time there are 5,000 such cases pending. In addition to the 5,000, there are many in which there is negotiation for settlement out of court, and some which are being dropped because they have no substance. Jury awards are sometimes out of line. Justice Miles McDonald of the New York Supreme Court says that 80 per cent of the awards in his area are excessive. They appear to be excessive in other areas also. The Consolidated Edison Co. of New York was sued by a boy who was injured in an explosion. The jury awarded the boy $600,000. When invested at interest this amounts to $30,000 a year with the principal still intact. *C. S. Bluemel, M.D. Ethics and Public Relations. Rocky Mountain M. J. April 1961.*

The View Box—diagnosis and discussion (*continued from page* 148)

The large bowel was normal. The left mid-abdomen shows a conglomerate of streaky and linear densities outlined by air within loops of small bowel. A tubular, worm-shaped shadow is distinctly noted to the left of the lumbar spine. These findings are pathognomonic of intestinal helminthiasis.

The absence of obstructive symptoms at the time of the colon examination made it possible to demonstrate the *Ascaris lumbricoides* by oral administration of barium.

Figure 2 demonstrates the tubular, radiolucent shadows of the worms within the barium filled bowel loops. Figure 3, a follow-up radiograph, shows the contrast material in the intestinal tract of the parasites and their surface coated with the barium after most of the barium has left the small bowel. Figures 2 and 3 demonstrate

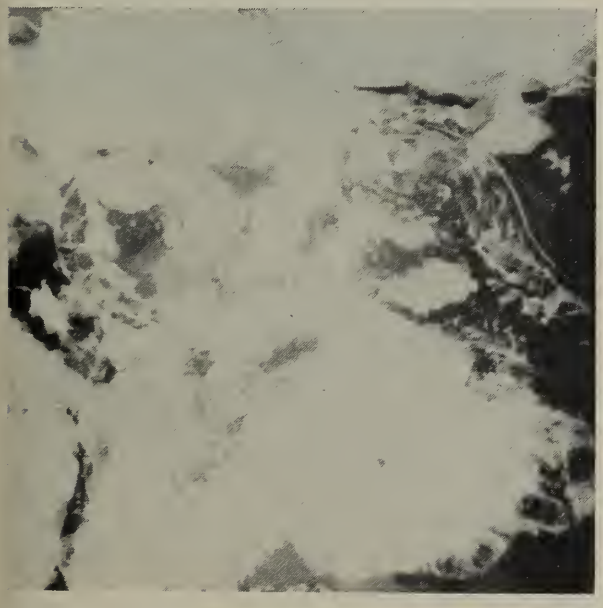


Figure 2. Radiograph after oral administration of barium.

the marked segmentation and irregularity of the small bowel pattern which may be associated with helminthic intestinal infections. This "deficiency" or sprue-like pattern is secondary to and nonspecific for parasitic infections.

Although the demonstration of Ascaris and other helminthic parasites of the intestinal tract by barium studies of the small bowel and the colon is well documented in the literature, it is



Figure 3. Radiograph after passage of the barium.

during the last few years that the plain radiograph of the abdomen has been utilized for the diagnosis of intestinal macroparasites. The pathognomonic finding is a conglomerate of string-like and tubular shadows within the air-filled bowel loops.

Complications of ascariasis include obstruction of the intestinal tract, chronic nutritional disturbances, and occasionally pulmonary complications. The pulmonary manifestations are due to the larvae which reach the pulmonary circulation via the thoracic duct and the venous circulation, causing pneumonic infiltrations and abscesses. Jaundice and pancreatitis are rare complications due to obstruction of the common and intrahepatic biliary passages or the pancreatic duct by the adult parasite.

The diagnosis is obvious when the adult worms and ova are recovered from the stool or a worm is noted in the vomitus. The radiographic demonstration of a parasite may explain a diagnostic problem of varied symtomatology in those patients who expel only a few or no ova in the stool.

FURTHER READING

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Dermatitis Following Furaltadone*

Charles A. Beck, M.D., *Chicago*

The quest for a drug with no adverse reaction parallels the search for the Philosopher's Stone, which turns base metal to gold, and promises just about the same degree of success.

So it is with furaltadone, a potent, valuable, oftentimes life-saving drug. It must be used with circumspection and with an eye to the calculated risk which it must be admitted is above the average of the usual antibiotic.

This is a clinical report of two similar cases of extensive dermatitis apparently caused by furaltadone. It is of additional timely interest because of recent reports of other toxic reactions caused by this drug.

In both of these cases the dermatitis was of a maculopapular nature which emerged on the face and forearms mainly, appearing bright red at first, changing to a dark brown and crusting over after the necrotic center broke down.

Case 1

M. P., a sixty year old white female was admitted to Jackson Park Hospital on July 23, 1960, with a left lower lobe pneumonia. The sputum culture would not grow out. We started with penicillin and demethylchlortetracycline (Declomycin®), shifted to chloramphenicol (Chloromycetin®) with still no effect, and then obtained a dramatic effect with furaltadone (250 mg. four times daily). This was started on July 29. The patient was discharged on July 31 with normal temperature and no cough. She remained on this drug for five more days while resting at home. Two days later she noticed on her chest a generalized rash that almost immediately disappeared and was replaced by one of entirely different nature on the face and extremities (mainly upper). The size of these lesions was about 3 mm. and when last seen on Aug. 15, 1960, they were still present although much faded.

Chairman, Research Division, Jackson Park Hospital, Chicago.

**Altafur.*

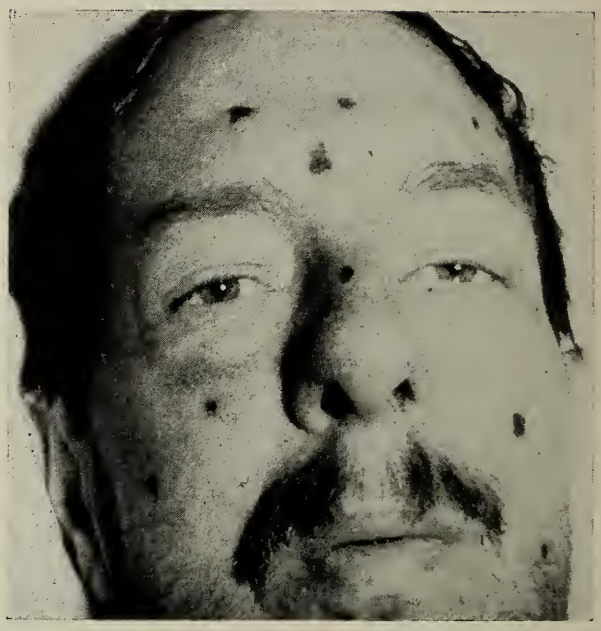


Fig. 1. Maculopapular rash nine days after its appearance (Case 2).

Case 2

A. B., a thirty-nine year old white male with Hodgkin's disease since 1954, was admitted for the sixth time to Michael Reese Hospital for nitrogen mustard therapy. This was his second course, as, having previously had maximum x-ray therapy, he could not be treated further by x-ray. He was admitted with high fever and intractable pain. The skin was hypersensitive because of the x-ray treatment but was entirely clear. Furaltadone was given on July 29, 1960, because of its indication on bacterial sensitivity tests. It was continued until August 2. It was then discontinued for lack of effect. Because of the patient's poor condition he received only half of his one-gram dose for two of these days. By August 7 a few lesions had developed on the face and extremities, and by August 8 he had many such lesions. They measured a mean 4 mm. and were maculopapular. They were raised about 1 mm. and had a center umbilicated necrotic area. Some became secondarily infected

because the patient picked at them although he stated they did not itch. On some there was a halo of infection, although most were not secondarily infected. They were present mainly on the face and upper extremities and slowly became less red and more brown as they crusted over and slowly healed. The patient was viewed with alarm by the nursing staff and other patients who felt this must be contagious. (It appeared much like the lesion of chicken pox, but multiple cultures of these areas grew nothing.)

Summary

As noted by the above, two patients, after taking furaltadone, were seen with skin lesions that appeared similar and followed the same natural history. It is suggested that extreme vigilance be exercised when using this valuable adjunct to antibiotic therapy.

The absence of a bibliography is not an oversight as nothing has been found in the literature on Altefur skin reactions.

SECRETARIES' CONFERENCE

on

Administrative Procedures of County Societies

and Their Relationship to ISMS

Chairman

Dr. Jacob E. Reisch with Dr. E. F. Moore assisting

Panel Discussions **Questions and Answers**

Luncheon Speaker

Dr. Franklin D. Yoder, Director

Illinois Department of Public Health

Sunday, October 8

Leland Hotel Springfield

Norethandrolone in Children with and without Cystic Fibrosis of the Pancreas

Ralph H. Kunstadter, M.D., and Robert S. Mendelsohn, M.D.*, *Chicago*

The underweight child and the child who fails to thrive are major "headaches" in the private practice of pediatrics. In most cases the history and physical examination suggest the reason for these conditions; but in many instances such studies are noncontributory, and elaborate laboratory examinations may be performed with little if any positive helpful information. Many children are underweight by standard growth norms but without discernible organic or psychologic basis. Nevertheless, they may create considerable concern in their parents and physicians. Also, even in those cases adequately explained by a proved organic entity, the child and his family may frequently be troubled by his thin appearance.

Many pharmaceutical products have been advertised as helpful in gaining weight, and it is not our intent to review them. The purpose of this paper is to describe our experience in a purely clinical study with norethandrolone (Nilevar®) an anabolic agent, with particular emphasis in children with cystic fibrosis of the pancreas. The latter were selected because of the inability of these children to thrive, in spite of management considered best at the present time.

Description of drug

Norethandrolone, a steroid chemically similar to testosterone, has been shown to have significant protein anabolic activity with considerably less androgenicity than testosterone.[1,2,3] While the mechanisms of nitrogen-sparing due to this drug are not well understood, some investigations indicate that an increase in lean body mass occurs as shown by measurements of body-water and increases in weight.[4] Extensive studies of electrolyte balance have shown proportionate retention of potassium and phosphorus; and since the amount of these substances retained appears to be proportionate to the amount of nitrogen retained, the assumption is made that protein synthesis occurs.[2,5,6] Undue salt and water retention were not found,[4,7] and there have been no reports of clinically apparent depression of adrenal function. Extensive studies of toxicity have shown few instances of jaundice and only mild transient effects on liver function tests.[8,9,10]

In view of these qualities and with the background of laboratory investigation, it seemed appropriate to use norethandrolone on a purely clinical basis.

Patient group

Forty patients from clinic and private practice were treated with norethandrolone since January, 1958. The age range was from 8 months to 14 years.

	Sex		
	M	F	Total
CFP	9	5	14
Non-CFP	17	9	26
Total	26	14	40

Diagnosis. Of primary interest were the 14 patients with cystic fibrosis of the pancreas (CFP). They have been followed by us for several years. In all instances the diagnosis has been confirmed by measurement of sweat electrolytes; in most cases study of duodenal enzymes has been done. All patients able to cooperate have had pulmonary function determinations. Treatment has consisted of daily prophylactic anti-

*From the Division of Pediatrics and the Pediatric Chest Clinic, Michael Reese Hospital, and the private practice of the authors.

biotics; various aerosolized solutions containing bronchodilators, saline (normal or 3%) or mucolytic agents, and in some cases, aerosolized antibiotics; supplementary vitamins; pancreatic enzyme replacement; and in one instance, digitalis. Patient response depended on the severity of the disease, but usually there was a good response to this established treatment. Patients had been treated for months to years with the above regimen before norethandrolone was started. This present group of 14 patients (of a total of 36 patients known to us) was available at the time, and most of them, in spite of prolonged intensive management, failed to thrive.

Other diagnoses include familial dysautonomia, bronchial asthma, celiac syndrome, mental retardation with congenital deformities, recurrent otitis media, and other chronic or recurrent upper respiratory infections. Also included were children whose parents considered them "thin," " poor eaters," "nervous," "small," and "not growing properly." In some instances their weight increment lagged behind their growth in height; in others the weight and height were proportionate usually (but with some exceptions) in low percentile ranges.

Method. The patients were examined monthly during and immediately following treatment. Monthly measurements of weight and height were recorded and, for patients under 13 years of age, were plotted on standard growth curves. Particular emphasis was given to the history of food intake, change in stools, change in activity and behavior, and other subjective effects the patients and parents might note. The usual physical examination was performed with special attention to genital changes. Complete blood counts, urinalyses, chest films, tuberculin tests, and some liver function studies were performed; no other laboratory procedures were done routinely. Pulmonary function studies were made at three to six month intervals on all patients able to cooperate.

Dosage. Since a dosage schedule was not previously worked out to our satisfaction, various dosages were used, ranging from 0.1 mg./lb./day to 1.0 mg./lb./day. The 10 mg. tablets were used in most cases. In a few instances, the liquid preparation containing 0.25 mg./drop was given. Depending on the dose, the drug was administered once or twice daily. Originally we prescribed ½ tablet (5 mg.) but discontinued this since the tablets did not lend themselves to easy division. It was not possible to demonstrate any difference in effect between tablet and liquid forms, and therefore, the results are tabulated together.

The duration of treatment was in most cases one to two months. When there was a good weight gain in the first month, we were encouraged to proceed with treatment for a second month. In a number of cases treatment was continued for longer periods. Several patients were given a second course at random or were treated intermittently over many months. The "end point" of this treatment is difficult to define, but as our experience mounted, it became obvious that the greatest weight gain usually occurred in the first month and that treatment beyond a few months was seldom justified. It was discontinued only because of lack of response, and in no instance did the side effects necessitate interruption of the drug.

Criteria for evaluation of weight gain

The following scale was used to indicate degree of weight gain:

- \+ marked increase in weight: definite change in slope of growth curve, frequently crossing two or more percentile ranges
- 0 no demonstrable effect: no weight gain nor an increment within the predicted range for this individual as measured on the growth curve
- ± equivocal effect: mild increase in weight, but no remarkable change

Results in patients with CFP

Results are summarized in table 1.

Gain in weight. Eleven of 14 patients showed remarkable gains in weight. Some of these seemed spectacular. One patient (No. 8) gained 6 pounds in one month on a second course of norethandrolone; another (No. 13) gained 5 pounds in two months, and on a second course gained another 4 pounds. Growth curves of one of these patients is presented (Fig. 1).

Patients 3 and 6 were well proportioned and above average in height and weight before treatment was initiated and did not show a significant response to norethandrolone; it has already been suggested that the undernourished individual is more likely to have and sustain a good result than the well nourished.[4] The best responses

TABLE 1. Effects of Norethandrolone on Weight of Patients with Cystic Fibrosis of the Pancreas.

No. of Patient	Age yrs.-mos.	Sex	Wt.* 6 mo. pre-Rx	Wt.* pre-Rx	Height† pre-Rx	Wt. gain on Rx	Dose mg./lb./day	Duration‡	Degree of Gain
1	8	M	33	33	45½	9	0.3	4	+
2	15	M	14	14	28¾	5	0.7	3	+
3	26	M	27	30	36	2	0.3	2	0
4	10- 6	M	49	51	50	5	0.5	1	+
5	17	F	14	16	29¼	8	0.6	8	+
6	3	M	33	33	38½	3	0.3	2	±
7	2-11	F	30	30	38	3	0.3	1	+
8	4- 4	M	31	37	42¾	3	0.5	1	±
	5- 1		40	41	43½	6	0.5	1	+
9	11-11	F	51	51	54½	7	0.4	2	+
10	8- 3	M	50	51	47	5	0.2	2	+
11	7	M	41	43	47	5	0.5	3	+
	7- 8		48	47	48½	4	0.2	1	+
12	3- 1	F	24	26	35¾	2	0.4	1	±
13	14- 8	M	65	59	60	5	0.2	2	+
	15			64	60	4	0.2	2	+
14	4- 4	F	26	26	40	4	0.4	2	+

* in pounds
† in inches
‡ in months

occurred in those children who were smallest and thinnest.

Following cessation of norethandrolone the patients were re-examined periodically over the next six months. Eleven of the 14 retained the weight gained, and some continued to gain weight. One (No. 2) lost 1 pound three months after treatment was discontinued. Two others died: one (No. 4) of fulminating Friedländer's pneumonia two weeks after his father had died of same disease; the other (No. 9) had far-advanced CFP, an episode of spontaneous pneumothorax, and chronic cor pulmonale, and died of heart failure. These patients had completed the course of norethandrolone three and eight months respectively before death.

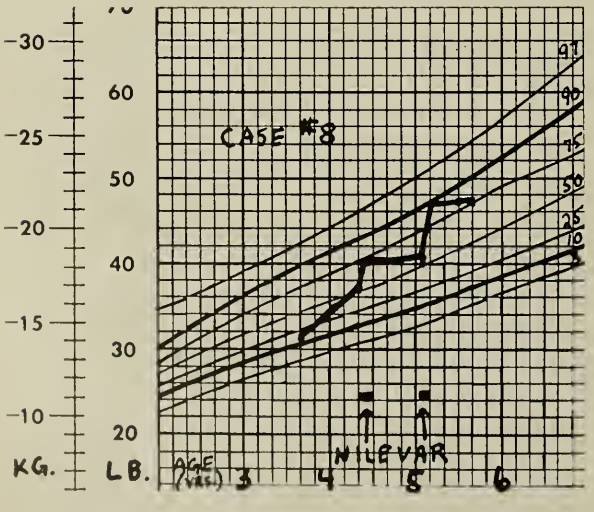


Figure 1. Growth curve of patient No. 1.

Gain in height. Height was measured before, during, and for at least six months after treatment. There was no noticeable clinical effect — either positive or negative — on linear growth.

Response could not be directly correlated to dosages used in this study. The range in this group was from 0.2 mg. to 0.7 mg./lb./day. Genital enlargement was seen in all patients regardless of dosage employed. One patient (No. 13) responded equally well to a second course of treatment; another (No. 8) responded better to a second course; in both cases the same dosage was used for both courses. On the basis of the general effectiveness, it seems reasonable to recommend 0.2 mg./lb./day.

Side effects. Genital enlargement occurred almost invariably in both sexes and caused little difficulty (other than frequent erections in a few males), and receded shortly after cessation of treatment. No other adverse effects were clinically manifest.

Other effects. Parents' comments, while admittedly subjective and influenced by reactions to any new drug, are still of some interest. Among the effects noticed were increased appetite, enhanced strength, and improvement in the stools.

TABLE 2. Effects of Norethandrolone on Weight of Patients with Conditions Other Than Cystic Fibrosis of the Pancreas.

No. of Patient	Age yrs. mos.	Sex	Condition	Wt.* 6 mo. pre-Rx	Wt.* pre-Rx	Height† pre-Rx	Wt. gain on Rx	Dose mg./lb./day	Duration Rx (mo.)	Degree of Gain
15	8-6	M	"eating problem; a nervous child"	47	49	48¾	4	0.4	2	±
16	7-7	M	Bronchial asthma; thin and pale	40	45	46¼	6	0.2	11	0
17	3-11	M	poor eater; frequent URI's	NA‡	29	37½	6	0.4	3	+
18	0-17	M	failure to thrive; hospital w/u negative	15	18	29	7	0.6	7	+
19	0-13	F	"poor eater"	15	21	29¼	3	0.5	5	0
20	8-4	M	"poor appetite and slow growth"	48	50	47¾	11	0.4	18§	±
21	0-14	F	bronchial asthma; no appetite; thin	15	18	30	1	0.5	1	0
22	0-19	M	mild mental retardation; congenital anomaly of lip; hypospadias	NA‡	19	30¼	1	0.5	1	0
23	3-1	M	"thin"	26	26	37	4	1.0	1	+
	3-4				30		1	0.7	2	0
24	3-3	F	"poor eater"; recurrent otitis media	23	24	34½	0	0.5	1	0
25	0-21	F	"no appetite"; large abdomen; "cries every night"	21	25	34½	2	0.1	3	0
26	0-21	M	"not eating or sleeping"; previous iron deficiency anemia	22	23	31¾	3	0.6	4	±
27	0-9	M	pale; thin; large stools	12	18	28	1	0.1	1	0
28	0-14	M	"small eater"	18	20	29½	0	0.1	1	0
29	3-6	M	familial dysautonomia; repeated pneumonias	28	29	36½	4	0.3	2	+
30	14-0	M	healed primary TB	58	58	54	2	0.3	1	±
31	0-22	F	"poor appetite"	21	23	31¾	4	0.5	8	0
32	0-8	F	"poor eater"	12	17	26½	9	0.6	12§	0
33	0-11	M	"poor appetite and not gaining well"	NA‡	19	29	3	0.1	3	±
	0-19			22	22	32	1	0.1	1	±
34	3-0	M	"eating problem"	27	30	36½	3	0.7	2	±
35	0-17	F	previous placental dysfunction syndrome; underweight	NA‡	15	28	7	0.2	9	±
36	3-0	M	"doesn't want to eat"	25	26	37	2	0.1	3	±
37	5-4	M	"thin"	31	31	41¾	9	0.6	3	+
38	8-2	M	"poor appetite"	NA‡	45	46	5	0.4	3	+
39	0-26	F	"poor appetite"; frequent URI's	22	22	34½	4	0.5	1	+
40	0-9	F	celiac syndrome	7	11	23¼	7	0.5	5	+

* in pounds
† in inches
‡NA not available.
§ intermittently

These were not necessarily related to the gain in weight, and many of the patients gained weight without noticing any change in appetite, activity, or stools. None of the routine laboratory measurements showed any change as a result of treatment. Serial pulmonary function studies were also unaffected by the drug.

Results in patients without CFP

Of the 26 patients without CFP, 8 showed marked gains in weight. One of these had familial dysautonomia and many episodes of pneumonia (No. 29), and one had the celiac syndrome and had been hospitalized several times (No. 40). Two others (No.'s 23 and 37) were thin children, and four (No.'s 17, 18, 38, 39) were said to have poor appetites and had frequent gastrointestinal and respiratory infections. Extensive hospital investigations in two of these (No.'s 17 and 18) did not reveal any cause for their complaints.

Almost all of the 26 patients gave histories of have been treated with various "tonics" in a futile attempt to "improve appetites" and promote growth." The list of products is impressive and expensive, including multi-vitamins, especially B_{12}, iron, liver extract, steroids, lysine and other amino acid preparations, tranquilizers, various diets, and mineral supplements.

In this group, as in the CFP group, there was no change in the rate of linear growth. Also, effective dosages were within a wide range, from 0.3 to 1.0 mg./lb./day.

As in the CFP group, temporary genital enlargement was common. One female infant (No. 32) who was given norethandrolone for several interrupted periods over a year's total duration developed a vaginal discharge and mild hypertrichosis; the clitoris in this instance was not enlarged. These changes disappeared after treatment was discontinued. Three other patients (No.'s 16, 20, 35) received medication for unusually long periods of time without any clinical evidence of adverse effect.

The weight gained, as in the CFP group, was retained in the majority of cases.

Total responses are presented in table 3.

TABLE 3. Response in Weight Gained in 40 Patients under Norethandrolone Therapy.

	Marked Increase	Equivocal	No Effect	Total
CFP	11	2	1	14
Non-CFP	8	8	10	26
Total	19	10	11	40

Discussion

This study demonstrates that norethandrolone is of value in increasing the weight of children with cystic fibrosis of the pancreas, especially those who remain undernourished despite intensive and prolonged management of the disease. Shwachman[11] has found the same results using the drug in 15 patients with CFP in a dose of 10 mg./day. In his cases, as in ours, the weight gained has been maintained. Thompson has also reported favorable results with norethandrolone over periods of less than two months; after this period, several of the children stopped gaining weight.[12]

There has been no effect on linear growth. There was no clinical evidence of toxicity even when the drug was given over a prolonged period of time. Spot checks of liver function tests showed no evidence of liver disease. Androgenicity was temporary and caused little discomfort. While there seems to be no evidence that the basic mechanisms of CFP are influenced, reports by the parents regarding better appetite, improvement in stools, and increased exercise tolerance should not be discounted completely. In addition, these reports may indicate future investigative approaches, especially in the area of metabolic balance studies in CFP.

In the non-CFP patients the results are less clear. There is considerable variation in response which cannot be explained by our data. Examination of table 2 and the growth curve patterns of each individual show that with similar conditions and similar previous growth records, some children gained weight well and others did not. Therefore, we do not recommend the drug for routine treatment of children who are "thin," "small," or have "poor appetites." Many parents in our society are anxious to have their children, especially boys, grow tall and often bring pressure on the physician to influence growth. These children who show satisfactory growth as measured periodically on growth curves are not candidates for norethandrolone. The pediatrician can manage this problem best by the established methods of reassurance of essentially good health

and encouragement of proper psychologic and philosophic attitudes.

In the case of these patients whose weight is below the expected range for height and body build, considerably more controlled clinical and laboratory study is needed to determine indications for a trial on norethandrolone, so that this potent agent will not be used indiscriminately.

Summary

This clinical study leads us to conclude that norethandrolone is a safe and effective drug for promoting and maintaining weight gain in patients with cystic fibrosis of the pancreas. Its effect in other conditions is erratic and requires further elucidation.

Norethandrolone was supplied for the CFP patients by G. D. Searle & Co.

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Limb fractures involving loss of skin

Fractures of limbs involving loss of skin require not only a close cooperation between the orthopaedic and plastic surgeons, but also that each must be a little bit of the other when occasion demands. The British Orthopaedic Association issued a further "Memorandum on Accident Services" in 1959 and properly draws attention to the undoubted fact that relatively inexperienced surgeons often have the initial handling of these difficult cases, and that subsequent progress is frequently determined by initial treatment.

In our series there are 118 cases of this nature, and I make a plea for the use of *free split-skin graft as a primary dressing*. It is the only dressing which can, and frequently will, heal the soft tissue loss forthwith; by so doing it can alter the picture entirely. If primary healing is not practical or wise, then graft as a delayed-primary measure.

In my opinion, the ability to cut a thin skin graft without destroying a valuable donor area ought to be within the compass of every surgeon who may have to treat a road accident case or a war wound. *Air Commodore George H. Morley. The Role of Plastic Surgery in the Royal Air Force. Proc. Roy. Soc. Med. January 1961.*

Famous Sons of Medical Men

Noah D. Fabricant, M.D., *Chicago*

Many physicians have turned to literature with distinction, among them such universally hailed figures as Francois Rabelais, Oliver Goldsmith, Tobias Smollett, Oliver Wendell Holmes, Anton Chekhov, Eugene Sue, Arthur Conan Doyle, and W. Somerset Maugham, to mention a notable few. Less familiar, however, is the surprising number of literary greats who were sons of practicing physicians. Just what this connotes opens up many interesting possibilities for medico-literary research.

One of the most famous scientist-writers of all time was Charles Darwin. Darwin's father was a country doctor who was an adherent of plain living but apparently of not too much thinking. One grandfather was not only a physician but also a botanist, philosopher, and a minor poet. Another grandfather, Josiah Wedgwood, was a manufacturer of the fine pottery so much sought after that the family attained social prominence as well as financial security. When Darwin was thirty years old, he married his first cousin, by whom he had five sons and two daughters. Her fortune and patience enabled him to carry on his scientific investigations and writing for more than 40 years despite a severe astigmatism, nausea due to gastric difficulties, and long periods of illness, actual and imaginary. The combination of genius, dedication, financial security, and a devoted wife permitted Charles Darwin to promulgate ideas on evolution which still reverberate throughout the world.

Fyodor Dostoevsky was born Oct. 30, 1821, one of seven children, in the dingy quarters of a Moscow public hospital where his father was a staff physician. Poverty, illness, and sudden death were the daily topics of his boyhood. Conditions for the entire Dostoevsky family became more sordid when the father, whose habits of drinking converted to chronic alcoholism, was discharged from the hospital staff and could barely support himself by private practice. Fyodor Dostoevsky antedated Sigmund Freud in his novels, which are distinguished by a profound understanding of abnormal psychology and by passages of intense introspection. Many of his novels, with their penetrating portrayals of life in nineteenth century Russia, reflect his own experiences, for Dostoevsky was an epileptic and he himself was active in the revolutionary movement in Russia.

Born some seven weeks after Dostoevsky, Gustave Flaubert also saw the light of day in a hospital environment. He was born in Rouen, Normandy, in the wing of the municipal infirmary, where his father was resident physician and chief surgeon. There were physicians also on his mother's side — Flaubert's maternal grandfather had been a country doctor — and it is conjectured that he inherited an ability to diagnose his characters as well as dissect them with almost clinical precision. Even as a child, Gustave was a writer. When he was nine years old he sent a letter to a youthful friend proposing collaboration. "If you wish to join us, I will write comedy, and you shall write your dreams and, as there is a lady who comes to our house, and who always talks silly things to us, I will write them." In time Flaubert became a distinguished and influential writer, his novels associated with the movement of naturalism and realism which swept over the French literary scene in the nineteenth century.

Marcel Proust, whose monumental work called *Remembrance of Things Past* constitutes one of the greatest novels of the present century, was born into a well-to-do, middle class French family on July 10, 1871. His father, Dr. Adrien Proust, was not only a practicing physician but also a professor at the Paris School of Medicine and head of the French medical health service. At the age of nine Marcel came down with asthma. He eventually became a chronic asthmatic, a semi-invalid who remained or, at least, was determined to remain a sick man until he died. Most of the final ten years of his life

were spent in an unventilated bedroom where he received his friends, going out only on rare occasions and then only at night. Together with James Joyce and Thomas Mann, Proust is rated by many critics as among the greatest novelists of the twentieth century.

Sinclair Lewis, the first American to win the Nobel Prize for literature, was born Feb. 7, 1885, in Sauk Center, Minn., the son of a country doctor whom he idolized and whom he idealized in his novels. As a novelist, Lewis became famous during the 1920's for his biting satires on the smugness, hypocrisy, bigotry, and vulgarity of American small-town life as he saw it at the time. *Main Street, Babbitt,* and *Elmer Gantry* aroused considerable controversy on publication. *Arrowsmith* and *Dodsworth* provide more sympathetic portraits of a doctor and an industrialist. In the 1930's, Lewis' novels tended to exalt the attitudes and institutions of the family, the middle class businessman, and the small town that he had previously satirized.

Ernest Hemingway, winner of both the Pulitzer Prize and the Nobel Prize for literature, was born in Oak Park, Ill., on July 21, 1899, the son of a doctor. His father was also a sportsman who, when Ernest was ten years old, gave the boy a man-size gun. His mother was an amateur musician who hoped Ernest would become a cellist. Hemingway first attracted attention as an American expatriate writer in Paris, a representative author of the "lost generation." His books expressed the disillusionment that was widespread after the first World War and dealt with drinking, physical sensation, sexual promiscuity, sentimental broodings on the past, and violent death. Hemingway's impact on literature has been impressive; during his lifetime he brought fresh life to American writing.

W. H. Auden was born Feb. 21, 1907, in York, England, the son of a retired medical officer. He is today a prominent poet. By the time he became a citizen of the United States in 1946, Auden was the author of four books of poetry, three plays, a collection of prose fiction, two books of travel, and three anthologies. His early poetry is characterized by its startling ingenuity, and social feeling breaks through clearly in some of his work. He is considered a superb technician, and there is apparently nothing he cannot do with rhyme and half-rhyme. At the end of the second World War his poetry became concerned with questions of philosophy and religion. Auden has had an important influence on a number of talented young American poets.

Smoking and emphysema

We believe that the observed reduction in expiratory flow rate among smokers is the forerunner of chronic obstructive emphysema. Presumably factors other than the mere number of cigarettes smoked play a role in determining the rate at which obstruction develops, as well as the degree attained. Individual susceptibility, intercurrent infections, and the manner in which cigarettes are smoked may all be factors. It has been postulated that the personality of the individual who smokes heavily differs from the one who does not, and that this rather than smoking per se accounts for the greater mortality from cancer and other disease in such individuals. It seems to us most unlikely that such individuals would also have poorer lung function. On the other hand, if smoking does cause bronchial obstruction, this may decrease the chances of survival in many apparently unrelated situations such as myocardial infarction, cardiac failure, or surgery for cancer of organs other than the lung. *William Franklin, M.D. and Francis C. Lowell, M.D. Unrecognized Airway Obstruction Associated with Smoking: A Probable Forerunner of Obstructive Pulmonary Emphysema. Ann. Int. Med. March 1961.*

The Case for Social Security

Roland R. Cross, M.D., *Chicago*

Sir William Osler gets credit for the statement that physicians "should never be the first to adopt the new, nor the last to discard the old." This is a true aphorism, and physicians have long endorsed and applied it to the use of penicillin, krebiozen, aspirin, and other new discoveries. The statement is just as true in its application to thoughts and ideas. Physicians now find themselves the last to be included in the compulsory Social Security program. One can wonder at length about the public relations aspect of being the "Johnny" in the phrase "Everyone was out of step but Johnny." Riekenbaeker and a large group would like to see the principle of income taxes abolished. A large segment of medical leadership would like to see Social Security abolished, but after 27 years of existenee too many people have too much interest in the Social Security system. We may feel that income taxes should be arranged in such a manner to permit a diligent man to plan his own retirement, but there is not one iota of a sign that either income taxes or Social Security is going to go away. Neither the Republicans nor the Democrats have any such plans.

Physicians have long argued that the Social Security system is not actuarially sound in comparison to a good insuranee company with its known and required reserves. The government cannot be compared to a private company since the company basically derives its stability from the government but not the government from any one company. The reserves for government are its taxing power. This is true as far as Social Security is concerned just as it is true of the dollar itself and of U. S. Government Bonds that have been the backbone of insuranee company reserves.

The title of Social Security is Old Age, Survivors and Disability Insuranee, and the title itself states the important areas for its use. Most physicians feel they work until they die and, therefore, do not need old age insuranee since they will be earning an income until death. For many, this is true. But how many are forced to continue practicing medicine because they do not have finances enough to retire? It is not unusual for a physician to continue trying to practice after his knowledge and mental powers have begun to wane. It is also true that some do not die but become partial invalids. It has been said that the National Safety Council, predicting the number of deaths on our highways for any given holiday period, emphasizes the wrong aspect; for none of us are as afraid of dying as we are afraid of being made a permanent invalid. So the slogan "The life you save may be your own" should be changed to "The paraplegic you make may be yourself." So too, we should place less emphasis on working and earning an income until we die from a cardiovascular accident and give more

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Social Security

Companion articles, one *for* and the other *against* Social Security coverage for physicians, appear on the adjoining pages. They are part of the educational preparation for a confidential poll of the membership on this question during the week of September 25. By action of the 1961 House of Delegates, a standard ballot will be used throughout the state with county societies electing to poll their own membership or accepting the results of a poll taken from State Society headquarters. Ground rules for the poll have been drafted by the Medical Economics Committee.

The official ballot, developed by the committee, will consist of four questions:

1. Are you now covered by Social Security?
2. If you are now covered by Social Security do you wish to remain so?
3. Are you in favor of compulsory Social Security coverage for all physicians?
4. Your age?

The following provisions for education of the membership have been made, in addition to the Journal articles:

1. County society officers were advised

These two articles were submitted by the Medical Economics Committee.

The Golden Goose In the Social Security System

C. Elliott Bell, M.D., *Decatur*

From its inception in 1935 the Social Security system has been grossly misrepresented to the American public by a long series of official salesmen, including the incumbent secretary of the Department of Health, Education, and Welfare, a succession of Democratic Presidents, various and sundry Senators and Congressmen, a host of Federal bureaucrats, and an increasing number of errant members of the medical profession.

The anesthetic qualities of the "sales-pitch" is well known to all — "it is just another form of insurance!" The government collects premiums from working employees, holds them in a "trust fund," and when retirement rolls around at age 65, pays them back in the form of monthly benefits.

Furthermore, these supersalesmen were able to implant in the public mind two additional concepts: (1) that each participant, through his own contribution, finances his own retirement program; and (2) that the "trust fund" thus created is adequate to meet all liabilities, both present and future, ad infinitum.

Simple! And also wonderful — if true. But herein lies the rub! All too soon the Social Security system developed a series of impending deficits, and its participants were confronted with a succession of increases in premiums (taxes). Gradually people discovered that the picture painted by the supersalesmen was a far cry from stark reality. With each passing year they became increasingly conscious of glaring deficiencies and of fundamental misconceptions about its economic structure. Periodic surveys by competent actuaries have revealed evidence of gross mismanagement as judged by currently accepted business practice, and of flagrant violations of regulations established by the Treasury Department for privately owned and operated retirement plans.

What are some of these deficiencies and what is their impact on the self-employed practitioner of medicine as he weighs the *pro's* and *con's* of participation in the Social Security program?

First, let us consider the fallacious idea that in the long run the average participant pays his own way, and just a little bit more. As a matter of documented fact, nothing could be farther from the actual truth. To date, and after 26 years, it can now be stated that it is a rare participant indeed who has carried, is now carrying, or will in the immediate future carry his own freight. The overwhelming majority of current recipients of retirement benefits have contributed substantially less than value received.

Furthermore, it is safe to estimate that no living physician, resident, intern, or medical student, starting from scratch in 1962 or any year thereafter, and having a minimum yearly income of $4,800 throughout all of his productive years, could possibly contribute enough to

for Physicians?

of the details of the poll by letter August 10, allowing ample time to arrange educational programs for their membership.

2. Ballots mailed from the State Society headquarters will be accompanied by a one-page summary of the advantages and disadvantages of Social Security coverage. County societies electing to do their own polling will have the further option of enclosing this or other materials with the ballot.

3. Details of the poll, including the wording of the ballot, were announced to ISMS members in August via the "Pulse" and "Springfield Newsletter."

Social Security coverage has generated considerable controversy among physicians with few conclusive results. It is hoped that the physicians in Illinois will take advantage of the opportunity afforded by this poll to acquaint themselves with the issues involved and then express themselves in conclusive manner by casting their ballot during the week of September 25. Results of the poll will be tabulated and published as soon as possible after October 10.

John R. Wolff, M.D., *Chairman*
Medical Economics Committee

finance (at present tax rates) the monthly income of $127 provided by Social Security for unincumbered male beneficiaries at retirement age.

And, incredible as it may seem, should there be legitimate dependents — say a wife, child, or unsevered parent — the monthly benefits would be increased to $190 or a maximum of $250 for no additional deposits. In other words, contingent beneficiaries get a free ride all the way for no charge whatsoever, currently or at any time in the foreseeable future.

Now — to purchase similar retirement benefits from a first-line participating insurance company, a practicing physician, starting at age 25, would need to lay on the line an annual premium of $425 for 40 consecutive years before he could provide for himself and living spouse monthly retirement benefits amounting to $190. Furthermore, if he purchased his insurance certificate at age 50, his annual premium would be in excess of $1,900 until retirement at age 65.

Under Social Security an annual tax payment of $288 would yield identical allowances — even though his tenure of participation was as little as four years if he reached age 65 in 1963, or no more than 10 years if he reached age 65 before 1980. In other words, for a minimum tax outlay of $1,152, the Social Security system will provide the same benefits that would accrue from an investment of $32,460 in a first-line participating insurance company.

So — all things considered, retirement benefits under Social Security systems is one of the biggest bargains in the history of mankind. The only fly in the Social Security ointment is "Who is the Golden Goose in this gigantic Gismo?"

Now, let us consider the second major fallacy — the matter of the so called "Trust Fund."

In the strict actuarial sense, there is no trust fund. Current benefits are paid out of current income. A small percentage of the annual income is laid aside as funded reserve. When current expense exceeds current receipts, the tax rate is boosted. But in the meantime the funded reserve suffers. Furthermore, and yet once again, we are confronted with another incredible fact. No provision has been made for contingent liability.

As a matter of record, in 1960 Social Security contingent liability amounted to $380 billion, of which only $21 billion were covered by its existing "Trust Funds." The remaining $359 billion were unfunded.

The gravity of this situation is beyond human conception. Nevertheless, one observation is self-evident. A day of reckoning must eventually come. Someone must eventually foot the bill. Someone must one day liquidate the growing amount of debt. Once again we raise a pertinent question — "Who is the Golden Goose in this gigantic Gismo?"

Let us consider the question of irresponsible management. The promulgators of Social Security retirement benefits have been warned repeatedly, and also officially, that the volume of unfunded liability must not be allowed to increase. Nevertheless, with flagrant disregard of these warnings, the gross unfunded liability has been allowed to increase each year during the past ten years — and the end is not yet in sight. Privately operated insurance carriers conducting their business in a similar fashion would be forced out of business before tomorrow's sun goes down. But the Social Security ship sails on and on oblivious to the storm signals flying everywhere.

Once more we raise the challenging query — "Who is the Golden Goose in this gigantic Gismo?"

In summary, it is obvious that retirement benefits under the Social Security system as we know it today are nothing more nor less than spurious handouts, payments for which have been deferred to the indefinite future and other and succeeding generations.

We say spurious because the giver is not the Federal government but posterity — or to be more precise, your son and my son, and their sons' sons. Here at long last we identify the Golden Goose. I do not know how others may feel, but as for us — the price tag on Social Security benefits is much too high. We are not willing, nor shall we ever be willing, to commit our children to the economic slavery which must surely follow, if we should choose to sell our souls for the meager subsistence benefits provided by the Social Security system. This is our decision, and this it will always be.

In the immediate future the physicians of Illinois will be given another opportunity to cast their votes "for" or "against" participation in the national Social Security program. As the hour of choice approaches, we urgently suggest that each and every member of the Illinois State

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For Social Security (*cont. from page* 164)

thought to being rehabilitated from the cardiovascular accident to live and enjoy life. This change in outlook requires some financial arrangement for such a period of loss of earned income.

The other part of the title is "Survivors Insurance" and from the physicians' point of view, this is the most important aspect. Physicians may work and have an earned income up to their deaths, but we should be more concerned about the survivors. Physicians do not wait to get married and have children today as they did twenty years ago. Sixty-two per cent of the senior medical students are married, and half of these have children already. Approximately one third of physicians die under the age of 60. Or to emphasize another aspect, about one out of six will not live long enough to see all of his children through with their education. Under survivors' benefits, a widow with two or more children under age 18 is entitled to 75 per cent of her husband's monthly benefit for herself plus 75 per cent for the first child under age 18 and 50 per cent for the second child. Under this provision, the maximum dollar benefit for a widow with two or more children, is $254 a month, or 200 per cent of the husband's monthly benefit. This is reduced to $190.50 a month when only one child remains under 18, after which the benefit ceases entirely until the widow is eligible for retirement benefits. Social Security is very important, therefore, to the young physician. It is, or should be, the true base on which he builds his estate in any estate-planning program. One might feel that the wife would get married again, but only one woman in 35 over the age of 35 will remarry (statistics from Home Life Insurance Agent, Mr. O. F. Little) because (1) her children are a handicap and (2) the male who is available to remarry will pick a woman fifteen years younger than himself.

The Survivors Insurance point is just as important for the older couple who have been fortunate enough to live and get their children educated and settled. Even here, the average woman survives her husband as a widow for six years. Thus, again it is emphasized, the physician may work until his death, but his widow does not have this income after his death.

In 1955 the Old Age, Survivors, and Disability Insurance Office made a sample survey[1] of the 201,000 physicians listed in the AMA Directory and found about 45 per cent had at least some credited earnings under Social Security law (and this did not include any credits which were automatically given to thousands of physicians as a result of blanket credits to them for military service), and almost one half of all physicians have a Social Security number that was received by virtue of credits acquired prior to self-employed private practice. (All physicians who served in World War II are entitled to Social Security wage credits of $160 for each month of active duty). With such a large number already covered or partially covered by Social Security, it would appear that a small, very conservative but very active minority is preventing coverage by all. This group is slowly being reduced each year as shown by *Medical Economics* survey[2] in which for the first time, over 51 per cent of physicians do not feel the AMA is properly and accurately representing their feelings in regard to Social Security coverage for physicians.

In summary, one could say the Social Security system is the true base which should be available to all physicians to start their estate planning program. In one way or another, a large segment is already making use of it. The program should be available to all.

REFERENCES

1. Reported in Newsletter, Committee on Social Security for Physicians, page 3, June, 1957.
2. Kauffman, H. H., Does the AMA Heed Your Views? Medical Economics, 38: 76 (June 5) 1961.

The Golden Goose (*cont. from page* 166)

Medical Society present himself at the shrine of sleeping childhood. And as he sees the living image of himself, we hope that he will find the proper answer to that all-important question, "When it comes to Social Security, just where do you stand, Dr. Jones?"

Blue Cross-Blue Shield Drive

Blue Cross-Blue Shield will open their enrollment plans for voluntary prepayment health insurance to all citizens in Illinois for a two-week period, October 1 to 15. The all-out campaign is dedicated to preserving the voluntary system of health care. Elements of the drive include the following:

- The 16,000 business firms that sponsor the plans will open them to all unenrolled employees.
- All persons over 65 will be offered the special *Over 65* plans.
- Persons under 65 may enroll in the *Non-Group Plan.*
- The new *H-300 Blue Shield Plan* will be included in the enrollment drive. It increases benefits to both patients and their physicians by paying more of the physician's total bill.

Blue Cross and Blue Shield along with physicians recognize the need for an effective mechanism that can help people pay for medical and hospital care that has become increasingly expensive over the years. To guard against the hazards of sickness and accidents, many good voluntary health care plans have been developed over the past 25 years. By good management, sound financial stability, and the absence of profit motive, Blue Cross and Blue Shield offer maximum benefits for each premium dollar.

The opening of the Over 65 plan, developed last year in cooperation with the Illinois State Medical Society, will allow thousands more senior citizens health insurance coverage. While physicians are not asked to become salesmen, their assistance and support is valuable. They can do much by recommending to their patients that they have some good dependable voluntary health care plan.

The support of every physician in helping to spread the news of this enrollment can be a valuable aid in forestalling a future compulsory plan to the elder segment of our population and the probable future extension of the compulsory plan throughout the field of health care.

Today doctors, hospitals, the para-medical services, and the prepayment plans are all members of the team that can preserve the free enterprise system of health care by defeating compulsory health care plans. The team must work together.

Straight Back Syndrome

Differentiation of true and false heart enlargement in routine chest x-rays films is best made by obtaining a lateral view of the chest to demonstrate heart compression or "pancaking" induced by the narrowed anteroposterior diameter of the chest. Normally, the degree of impingement upon the retrosternal space varies with the shape of the thorax, the degree of inspiration (when it is closer to the sternum), and the amount of pericardial fat or obesity. To be included in this list now will be the "Straight Back Syndrome" in which the retrosternal space is usually obliterated.

Often the degree of straight back deformity is insufficient to produce heart shadow enlargement, but is sufficient to compress the aortic arch or impinge upon the main pulmonary trunk to create mechanical murmurs. The pulmonary conus lies against the inner surface of the sternum in most of these cases, and perhaps could transmit sounds more readily for this reason. The aorta, anchored at the root of the heart and at the diaphragm, is subject to torsions at the level of its arch and could conceivably create murmurs. Moreover, the straight back syndrome tends to feature an aorta that descends completely anterior to the dorsal spine, appearing to be a more midline structure than usual. The exact etiologic mechanism of the murmur found in this syndrome, however, is not clear. *Maurice S. Rawlings, M.D. Straight Back Syndrome: A New Heart Disease. Dis. Chest. April 1961.*

EDITORIALS

Rebound in rheumatic fever

The rebound phenomenon in rheumatic fever is defined as the reappearance of clinical and/or laboratory evidence of rheumatic activity after treatment is reduced or stopped. There is no intervening streptococcal infection. The condition was investigated thoroughly in 415 children and adolescents admitted consecutively to Irvington House in New York. Laboratory rebounds occurred to 96 patients as determined by the sedimentation rate and serum C-reactive protein. All recurrences subsided spontaneously without adverse clinical effects. Additional suppressive therapy was of little value and only served to prolong the period of invalidism.

Clinical rebounds — as manifested by fever or joint pains or new cardiac signs — together with laboratory abnormalities took place in 64 patients. In 39 of the first 49 cases reported the rebound occurred while medication was being reduced or during the first post-therapy week. It was more prevalent among those receiving steroids or combined steroid-salicylate treatment than in those treated with salicylates alone. The longer steroids were used the greater the incidence of the rebound phenomenon. This was true particularly among those with substantial initial cardiac damage.

The patients who escaped valvular involvement during the initial attack did not develop cardiac manifestation during the rebound. Additional treatment was not needed in this group. Those with valvular involvement but without significant cardiac enlargement often developed new cardiac manifestations such as a diastolic murmur. The new findings usually disappeared whether or not treatment was administered. Salicylates were preferable to steroids in these cases because they were less likely to be followed by a rebound.

The group that required the resumption of anti-inflammatory therapy were those with significant initial cardiac enlargement. Many had pericarditis, increasing cardiomegaly or congestive heart failure. Therapy was mandatory even though its cessation usually was followed by another rebound.

The authors found that clinical rebounds could be prevented by avoiding the use of anti-inflammatory agents such as the steroids for the initial attack or by treating the initial attack with salicylates alone for eight or more weeks. The incidence and severity of rebounds among those on steroids was lessened by adding salicylates to the plan of treatment or reducing steroid treatment and by continuing salicylates several weeks after steroids were stopped.

1. Spagnuolo, M., and Feinstein, A. R.: The Rebound Phenomenon in Acute Rheumatic Fever. Yale J. Biol. & Med. 33:259-298, (Feb.) 1961.

Salute to the Army Medical Service

Congratulations to the U. S. Army Medical Service, which celebrated its 186th anniversary, July 27. The service has had a long and distinguished history during peace and war. It contributed countless benefits to civilian and military personnel and to the wealth of professional literature from its posts around the world. It has accomplished much over the year. For example:

- A comprehensive guide for both military and civilian post-mortem examinations was published last fall.
- Added emphasis has been given to geographic pathology at the Armed Forces Institute of Pathology, which has traditionally demonstrated a keen interest in tropical and exotic diseases.
- The U. S. Army Environmental Hygiene Agency called in a panel of experts in the field of nuclear physics to assist in the formulation of policy and guidance for controlling extraordinary exposure of personnel to ionizing radiation re-

sulting from the operation of, or accident to, Army nuclear reactors. During the past year studies have been initiated on health hazards associated with the disposal of missile fuels and oxidizers at an Army Ordnance installation. Indiscriminate disposal of such chemicals could result in both atmospheric pollution and contamination of underground water supplies.

• A large-scale field evaluation of a new malaria pill, which combines chloroquine and primaquine, is presently in progress in Korea.

• The U. S. Army Medical Research and Nutrition Laboratory at Denver has accumulated adequate data to disprove the age-old concept that man's energy requirements are greater in cold than in hot climates. In contrast to previously held beliefs, controlled studies indicate that the soldier actually has a higher caloric requirement in hot climates.

• A major research project that promises to have considerable potential for surgery under combat conditions as well as for civilian medicine, was first demonstrated in the United States in January, 1961. Through continuous electrical impulses, the anesthesia sends the patient into varying degrees of unconsciousness followed by prompt recovery without nausea or other unpleasant postoperative aftereffects.

• Another research project which has great potential is the light-weight, portable field x-ray unit, which can be carried in a medium-sized suitcase and operated from a battery, if electricity is not available.

• The Medical Equipment Development Laboratory is working on plastic surgical and dental instruments made of polycargonate resins, capable of withstanding high autoclaving temperatures, and having a high tensile strength and shock resistance.

• The Army Prosthetics Research Laboratory is using plastics for artificial limb sockets. This new plastic laminate allows for the rapid evaporation of perspiration, the accumulation of which caused considerable discomfort previously.

• For nearly 15 years U. S. Army doctors have been working with the Japanese medical authorities in searching for a means of eliminating schistosomiasis. More than 3,000 chemicals have been screened by the 406th Medical General Laboratory in an effort to find a cheaper and more effective chemical means of eliminating the disease carriers.

Revised images

The Boston University Human Relations Center believes that the threadbare image of the nurse as one concerned only with the care of bedridden patients should be revised. This image has not kept pace with the expanding interests of the nursing profession in industry, outpatient clinics, research, and administration.

Those engaged in nonhospital projects are upset because their work is not considered real nursing. As a result, there is low motivation for nurses to seek advancement because promotion usually means less nursing and more administrative duties.

The nurse has been trained to think for herself as a professional person capable of making independent judgments. The modern nurse finds it difficult to accept being treated as only an extension of the physician's judgment. This is a basic source of her conflict and tension. There is too wide a discrepancy between her ideal and her actual performance.

The Boston University report suggested that the loyalty of the nurse should be directed toward the nursing profession rather than loyalty to a particular hospital. The role of the nurse should be expanded to include those not giving direct care to the physically ill, hospitalized patient. The report warns that unless nursing education recognizes the unlikelihood of many nurses practicing bedside care, the profession will continue to build the basis for dissatisfaction and to intensify the adjustment problems of today's nurse. Their teaching program must provide the student with new criteria for judging her performance in a variety of settings and circumstances.

There are many ideas in this report that apply to the medical profession. We are finding it increasingly difficult to sell our image (country doctor at the bedside) to the public and to students. This image must be changed. It must be modernized to include teachers, administrators, researchers, medical writers and those who work with industry, public health, and the armed services. Established images are difficult to change, but our enemies are doing a good job of changing ours to foster their socialist views. If we cannot hold our old image, we must come up with something that appeals to the public and to our entire profession.

Five boiled tumors

We received recently a reprint on Language Dystocia by Drs. Lewis B. Posner and A. Charles Posner published in the *New York Physician*. Patients describe their symptoms in many ways, and the senior author became interested while a student at Bellevue. A middle-aged longshoreman with incontinence of urine and feces who could not move his legs stated that he had been "caught in a draft." He was found to have active tuberculosis, Argyll Robertson pupil, aneurysm of the aorta, positive serology, and carcinoma of the prostate. The diagnosis was obviously tabes, tuberculosis of the spine, or perhaps metastatic carcinoma.

But the late Professor Carlyle deflated the group by making the correct diagnosis before seeing the patient. He knew that a draft was a load of freight. The man had a fractured spine.

The authors list many other examples: The common dilatation and currettage has appeared as "Draping," "Seize and Tease," "Disease and See." Women have called fibroids "Five boiled tumors," "Fiberloid tumor," and "Fibrous my owner." Hysterectomy was described as "His to wreck me," "wisteriaectomy," "mysteryectomy," and an "Everything operation."

The layman is learning medical terminology, and it is surprising how frequently the different organs and technical procedures are mentioned correctly. The physician will do well to acquaint himself with the many new terms and slang expressions of the skilled workers who handle (and are injured by) equipment that did not exist twenty years ago.

Plans call for cash

A University of Michigan research team made the following suggestions to overcome the shortages of health care personnel and to make better use of available personnel:

1. Stepped-up government subsidies for medical students and related educational and research facilities;
2. Intensified efforts by all professional groups to achieve better distribution of health care personnel within the state;
3. Greater development and use of paramedical personnel—physical therapists, technologists; etc., to increase the productivity of physicians;
4. Longe-range, cooperative study of relations between various professional organizations, including eventual merger of the state medical and osteopathic societies; and
5. Creation of state-wide commission on health manpower to provide up-to-date information and studies in this field.

They emphasized that expansion of Wayne State University Medical School to accommodate 200 entering students and that construction of a third medical school would be needed to help meet the problems.

But they placed a $50 million price tag on building a third medical school. It is doubtful whether the state will go for this considering the financial status of Michigan. The operative budgets requested by Michigan colleges and universities have not been met in the past five years. Under their present operating budgets they lack the money to build the school; and if the money is obtained, the operating requirements of a new medical school would be substantial. Incidentally, Grand Rapids was a highly desirable choice for the location of the school.

The root of all evil

The American Medical Association, Council on Medical Education and Hospitals, reported recently an improvement in stipends for interns and residents. The average monthly cash payment to interns in hospitals affiliated with medical schools increased 7 per cent ($166), whereas in nonteaching institutions the stipend went up 4½ per cent ($207). There were other benefits, including maintenance for some. Similar increases were noted for residents. For example, a total of 16 residents were paid more than $600 per month, including eight over $700 and two over $950. Last year there were only six over $700 and none in the $950 bracket.

We do not begrudge these increases, but it has sad connotations for the following reason: We asked the late Dr. R. Barratt Terry to write an editorial on the events preceding the socialization of medicine in the British Isles. He accepted the request but shortly thereafter was found to have an inoperable gastrointestinal lesion that led to his death a few months ago. Dr. Terry was an English physician who was trained in London. He decided to make his home in America and settled in Chicago. He maintained that the high

stipend to interns and residents in England made it easy for the government to sell compulsory health insurance to the younger physicians. They were accustomed to a comfortable government or private subsidy and found the gap between medical training and the establishment of a practice too much of a hardship. It was easier to join the medical program instituted by the labor government.

Holding talented students

The most important problem facing U.S. medical schools in their bid for talent is holding on to those quality students who express an initial interest in going into medicine. Many of these high-ability applicants are discouraged when turned down by certain schools and seek a career in other fields. Meanwhile, schools with lesser reputations are forced to seat their first year classes with at least some mediocre or poor students. The basic research division of the American Association of Medical Colleges is studying this problem, hoping perhaps to establish a pool of available applicants.

This might go a long way toward distributing talented students among the various schools.

Role of the family specialist

A not inconsiderable segment of the American public is said to project two diverse images of the doctors who provide them with medical attention. The American doctor is pictured either as a modest, self-sacrificing general practitioner, who, while pulling the ailing multitudes through their trials and tribulations, receives little applause for his own medical achievements. Or he is thought of as a specialist, one who is admittedly a highly knowledgeable medical machine, efficient, cold and impersonal, with little time for inquiry into the personal lives of his patients. Neither of these stereotyped portraits is satisfactory, but there is enough truth in each image of the American doctor to warrant a modicum of soul-searching.

It seems to me that what many specialists need is not so much an improvement in public relations as an improvement in human relations, if the image of their cold, impersonal efficiency is to be altered. To combat existing prejudice against such a portrayal, it might be well for the average specialist to begin to think and function as a *family specialist*, a term which I have coined and hope will receive wide circulation as its implications become better known.

It is not enough for the *family specialist* to undertake a thorough and exhaustive clinical and laboratory study of the patient to rule out obscure disease and to convince the patient that the investigation has been complete. Therapy begins with the very first contact between patient and physician, is maintained through the physical examinations, and hinges pre-eminently on the interviews.

The *family specialist* must, if he is to live up to the designation, give the patient a great deal of time and exhibit a world of patience. He will often find that the patient is faced with real difficulties in his daily life. To alleviate them may involve dealing with family members. A brief history from a close relative sometimes throws a revealing shaft of light on a patient's problems. Sooner or later, the *family specialist* will find himself in an ancient historical role—that of a healer, with or without benefit of religious faith. He will find himself relieving familial anxiety about the sick person; discussing the problem of tangled emotional relations with the husband, wife, or parents; functioning as a marital counselor in the sexual problems of husband and wife; or acting as a impartial arbitrator in family disagreements. A sympathetic attitude displayed by an understanding *family specialist* is, more often than not, completely beneficial to his patient.

Patients who are given insight into their own reactions to daily living can be shown how to reduce or avoid tensions. Reassurance, suggestion, and re-education are valuable weapons employed by all tactful physicians in the ventilation of a patient's underlying emotional conflicts. The patient, in short, must be considered as a human being rather than a collection of tissues and organs to be treated impersonally by the specialist. Since problems vary from patient to patient, the *family specialist* who employs a pinch of medicine, a sprinkle of patience, and a huge dose of understanding and compassion is able to help many patients with organic and psychogenic difficulties lead healthier, happier lives. And this, of course, is the function of all competent physicians. *N. D. Fabricant, M.D. Eye, Ear, Nose & Throat Monthly.* (*April*) 1960.

PKU study

The Children's Bureau is showing an interest in phenylketonuria (PKU), an inborn error of metabolism that leads to mental retardation unless detected early and treated by a diet low in phenylalanine (Ill. M.J. July, 1961). Mead Johnson has a brochure on this subject in which Lofenalac is featured as a low phenylalaline food.

At least 25 infants with the condition were discovered in clinics last year at an age when retardation could be prevented. The bureau will make a long-range collaborative study into the effects of the disease.

Correspondence

Public Health Versus Private Medicine?

Certainly not! There are well established precedents and practices of public health in this country. Such services do not encroach upon the private practice of medicine, which has been responsible for major advances in the care of the sick, which has made American medicine preeminent in the world today, and which has extended the understanding of human ills more in a brief span of years than in previous centuries of recorded history.

Public health services are based upon the principles of the promotion of known factors of proper nutrition, adequate sanitation, comfortable shelter, and the prevention of illness.

Private medicine is concerned primarily with the treatment of the sick or disabled individual and the development of new substances and new methods which will correct errors of organic or functional development and injury or illness caused by specific agents.

I wish to emphasize that public health implies services to the many while private medicine is the specific treatment of the individual.

Only on a public basis has it been possible to provide, for example, survey screening procedures such as chest x-ray programs for case finding. This is a public health service.

Proper supervision of water supplies and waste disposal, sanitation of public food services, and the problems of controlling insanitary nuisances can be prepared for and performed only by a public health service.

Adequate follow-up of patients with communicable diseases, particularly tuberculosis and venereal disease, and follow-up of their contacts are properly public health services.

Health education is also properly the role of public health services since the purpose is to prevent illness, while the role of the private physician is to use his highly specialized knowledge and skill for the treatment of the sick.

Special illness problems of the poor and ignorant can be sought out and disposed of adequately only by public service with nurses trained and sympathetic with the difficulties of families unable to take advantage of private care. The time involved in instructing these people in personal cleanliness, adequate nutrition and the like is not available to the private physician.

Controversy sometimes arises in communities today because physicians fear that local public health units may in some way interfere with individual care. As a private physician with several years' experience as an officer of a tri-county board of health, I know this is not true.

On the basis of this experience with local and state public health services I believe that physicians and medical societies should do all they can to promote the widest and most effective organization of public health services.

William H. Whiting, M.D.

Employment, which Galen calls "nature's physician," is so essential to human happiness that indolence is justly considered as the mother of misery. — *Burton*

AT THE EDITOR'S DESK



HEW don't say so!

Histoplasma capsulatum, the fungus which causes histoplasmosis, has gone to our nation's capital. It was found in soil contaminated by starlings and taken from beneath sycamore trees in two of Washington's parks. We were surprised to hear that this discovery rated a news release from the U.S. Department of Health, Education and Welfare. It was considered news, we assume, because the fungus usually grows only in the soil of rural areas and small towns.

It must have been a shock to discover organisms usually found in barnyards, chicken coops, and pigeon lofts under trees in parks on Massachusetts and Pennsylvania avenues.

HEW officials are probably having fun concocting ditties along the rural lines of "Don't sit under a sycamore tree unless you want pneumonitis with me" or "Starlings are no darlings."

Radioactive Hippuran

The Veterans Administration has developed a new radioactive agent for use in the diagnosis of kidney disease. It is radioactive hippuran which, it claims, differentiates between high blood pressure of renal origin and the more common forms of hypertension. The substance is injected intravenously, and the speed with which it is eliminated offers an index of kidney function. This is measured with radiation dectectors placed over the kidneys.

They hope to use the method to screen out the 5 to 15 per cent of patients with a curable type of hypertension caused by kidney disease.

Pharmaceuticals

The antimalarial drug Aralen (Winthrop), used on seven patients with chronic sarcoidosis, resulted in considerable improvement of the cutaneous lesions. Marked clearing occurred within one or two months, but maximal benefits usually required six months of therapy.

Parkinson's Disease on Increase

A Public Health Service publication reported recently that there are 300,000 victims of Parkinson's disease in this country. Furthermore, there are more than 25,000, possible as many as 43,000 new cases each year. The reason — more older people. And the number is likely to increase unless a preventive is found. The government has a pamphlet on the disease written to inform and reassure the victims and their families. "Parkinson's Disease — Hope Through Research" is listed as Public Health Service Publication No. 811 and Health Information Series No. 100. Single copies may be obtained without charge.

Worthless Warnings

The Religions Committee of the National Safety Council suggested that the clergy stress the commandment, "Thou shalt not kill," on the Saturday or Sunday preceding Labor Day. It was an excellent idea but had little influence on drivers of automobiles; warnings from God are as meaningless as those from traffic authorities.

RNA and Heredity

Samual B. Weiss and Tokumasa Nakamoto, two University of Chicago scientists, presented a paper on a new method of making ribonucleic acid in the test tube before the National Academy of Sciences in Washington recently.

They described a method of synthesis of ribonucleic acid (RNA) which offers the first plausible explanation for nature's transmission of messages about heredity from one part of the living cell to another. It is undecided whether the RNA which they have synthesized is biologically active; this is in the process of being determined. Theirs is the first work to specifically point to a biochemical mechanism by which information may be carried fom DNA to RNA to proteins and enzymes. RNA, one of the

two vital substances in the living cell, controls the protein and enzyme makeup of the cell. It is believed to deliver genetic instructions from DNA (deoxynucleic acid) to cell manufacturing centers.

Mr. Weiss is an assistant professor of biochemistry and Mr. Nakamoto a research associate at the Argonne Cancer Research Hospital, operated by the University of Chicago for the Atomic Energy Commission.

Eli Lilly's Sample Policy

Commissioner Larrick has warned pharmacists against filling prescriptions with samples. Eli Lilly and Company want it known that no Lilly products subject to the Durham-Humphrey Law may be presented to anyone except licensed physicians and dentists. In addition, all Lilly salesmen have been carefully instructed on the proper distribution of sample materials. You are also reminded that samples in your possession are to be stored in a locked cabinet to which only you have access.

Private Hospitals Decreasing

During the past 15 years the number of hospitals sponsored by state and local governments increased 55 per cent while the number of privately owned or proprietary hospitals dropped more than 17 per cent. According to *Patterns of Disease,* there are 1,378,035 hospital beds in the U.S. exclusive of those in Federal facilities (7.5 beds per 1,000 population).

The District of Columbia has the highest number of beds per 1,000—17.8, followed by 14.0 in New York and 13.2 in Massachusetts.

Simian Malaria

The mosquito that transmits malaria to monkeys in nature was identified recently by a team from the Public Health Service. The species, *Anopheles hackeri,* is regarded as a rather rare mosquito breeding in split bamboos in inland forests. It is quite common, however, in the Selangor coast of Malaya. Whether this species transfers simian malaria to man remains to be proven. For some time malaria investigators have been concerned with the possibility that monkeys acted as a reservoir for the parasite. This study lends some support to the theory that some types of malaria infecting lower animals could be inoculated successfully into man. Time will tell.

Safety Belt and "Blowby" Required

The General Service Administration was praised by Secretary Ribicoff for improving Federally purchased motor vehicles. Hereafter, the government will require seat belt anchors for passenger safety and a "blowby" device to reduce air pollution. This is a positive crank case ventilation system that reduces total automotive emissions of hydrocarbons by 25 per cent.

Accurate Flowmeter Designed

A flowmeter was developed at the University of Chicago that measures velocity and volume of blood flow without opening the blood vessel. It is said to be within a 5 per cent range of accuracy.

Since 1937 scores of flowmeters have been designed, but all have been inaccurate in actual use. Drs. Walter Feder and Emmett B. Bay have made improvements growing out of developments in electronics and electrochemistry.

The principle of the flowmeter is based on an observation made in 1832 by Michael Faraday. He stood on Waterloo Bridge in London with a simple galvanometer, the same basic instrument as the present-day DC flowmeter. Faraday saw the dial swing with the change in the flow of the Thames' tide. He proved that water induced an electrical potential that could be seen on the dial as it crossed the field of the magnetic force of the earth.

FDA Activity

Amphetamine tablets are sometimes called *bennies* or *dexies* and are dubbed *copilots* or California *turnarounds* by truck drivers using them to stay awake on exceedingly long cross-country hauls.

Almost every month the FDA reports the arrest and conviction of several peddlers and pharmacists for selling amphetamine tablets without a prescription. Their use can result in habit formation, highway accidents, and serious health disturbances.

Siezures by the FDA during July included 17 tons of canned cat food. It was labeled "Chicken Dinner with the taste appeal of plump, country

fresh roasted chicken." It consisted of chicken viscera, backs, and necks plus fish and cereals.

Cats can't read, and we doubt if they would have been misled by the label. "Country fresh roasted chicken" sounds mighty tempting, and perhaps the FDA seized the shipment to protect cat owners who raid the refrigerator after letting the cat out for the night.

The whole idea demonstrates what some people go through to make a buck. The label was prepared to whet the palate of the owner rather than the cat. The latter may have preferred a mixture with more fish and viscera.

Vacuum Toothbrush

A new suction toothbrush that vacuum cleans the teeth was described recently in the *Journal of the American Dental Association.* There is a hole in the head of the brush through which a plastic tube is inserted. The tubing extends from the bristle tips down the handle of the brush to the suction apparatus.

Hospital costs survey

Charges for such basic hospital services as room, board, routine nursing care, and minor supplies average from $15 to $20 a day in hospitals across the nation, according to a new American Hospital Association survey published May 1. Although figures in the new survey cannot be compared with complete accuracy with those used in earlier ones, a general increase in average charges was noted. The report indicated this probably reflects not only rising hospital costs but also a trend toward a more realistic balance between charges for routine daily services and unit charges for special services.

Rates vary widely according to type of accommodation, hospital size, and ownership, and geographic area. Fifty-four per cent of all beds are in accommodations within the range of $12 to $20 per day; 27 per cent range from $20 to $28; 15 per cent are below $12; and only 4 per cent are $28 or over.

Average daily charge for all hospitals, according to accommodation, were: single-bed, $20; two-bed, $17.50; three-bed, $16; four-bed, $15.80; five-bed, $15; and six or more, $15.10.

The new survey, "Daily Service Charges in Hospitals, 1960," uses figures obtained from 4,692 short-term nonfederal hospital having a total of 543,758 beds. This is 94 per cent of such hospitals listed by the American Hospital Association.

Inconsistency

People are interesting. The following discussion between a man and two women was overheard several weeks ago, while I rode on a bus along Lexington Avenue in New York.

"My doctor charges me $10 a visit," said one of the women, "but he is so kind and understanding that I don't mind it."

The man replied, "For $10 he can afford to be understanding and kind. They all charge too much."

Six blocks later, the conversation switched to shoes, and the man remarked, "Fifteen years ago I was able to buy excellent shoes for $8. Now I am lucky if I can find them for $28."

Back in Chicago, the elevator stopped at the seventeenth floor. An alert man and a slightly pregnant woman stepped on. She was young and prim, and probably a secretary in his office.

"It's windy and raw outside," said he.

"And I have an appointment to see my doctor in 20 minutes" said she.

"That's terrible. Call him and tell him to come to see you?" our man bellowed.

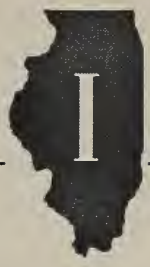
She said nothing, but the flush on her face supplied the answer.

Illustrated PG courses

Another "postgraduate course at home" is being offered by Loma Linda University School of Medicine at Los Angeles. Each Illustrated Medical Lecture is a thirty-minute audio tape and an accompanying full color 35 mm filmstrip that can be projected on a screen by any standard projector or viewed through a hand or desk viewer. Three lectures per month will be released and provided at a cost just under $400 per year.

For further information address Film Distributors International, 2223 South Olive St., Los Angeles 7.

ANNOUNCEMENTS



Dr. C. A. Smith to edit *Pediatrics*

Dr. Clement A. Smith of Boston becomes editor of *Pediatrics,* monthly journal of the American Academy of Pediatrics, on October 4, succeeding Dr. Charles D. May, New York, who retires after over seven years in the position.

The new editor is well known for his many published papers dealing with the prenatal and early newborn child, and is author of "The Physiology of the Newborn Infant," now in its third edition. Dr. Smith received his medical degree at the University of Michigan. Since 1945 he has been director of research on the newborn at Boston Lying-in Hospital, associate professor at Harvard, and on the staff of Children's Hospital and Children's Medical Service at Massachusetts General Hospital.

Dr. Smith served as chairman of the Josiah Macy Conferences on Physiology of Prematurity, 1956-1961. At the annual meeting of the academy this fall, he will add to his honors the Borden Award for outstanding research in infant nutrition.

PG Medical Association's 1961 Assembly

The Interstate Postgraduate Medical Association of North America will have its 1961 Assembly in Cleveland November 13-16. Two Chicago physicians, Orvar Swenson and John L. Keely, will participate in the program, which features demonstrations, lectures, morning color TV, and special entertainment for physicians' wives. It offers a maximum of 25 hours of category II credit acceptable by the American Academy of General Practice.

For full details and hotel reservation forms write E. R. Schmidt, M.D., Secretary, Interstate Postgraduate Medical Association, Box 1109, Madison 1, Wis.

Medical writers to gather In New York

For the first time the American Medical Writers Association's annual convention will be in New York City, Friday and Saturday, October 6 and 7, at the Belmont Plaza Hotel. Six half-day clinics on problems of major concern to medical writers, editors, and others in the field of medical communications have been arranged to make it possible to attend one session of at least four of the clinics. There will also be a seminar on Advanced Medical Writing on Sunday, October 8.

Dr. T. R. Van Dellen, editor of the Illinois Medical Journal and president of AVMA, will preside at the general session. Dr. Morris Fishbein of Chicago, editor of *Excerpta Medica,* will lead the clinic on Rationale of Stylistic Conventions for Journals, and Miss Martha Dana, assistant editor of the Illinois Medical Journal, will be a discussant on the panel.

Discussion topics for other clinics are Respective Responsibilities of Journal Editors and of Authors for Literary Competence, Ethics of Writer-Investigator Collaboration, Breaking the Language Barrier, Graphic Arts and Audio-Visual Presentation of Medical Information, and Selling Products and Images.

Some of the planned events are edueational exhibits in the field of medical communication, a nightlife tour, theatre party, scenie boat ride, and the president's reeeption and banquet.

Registration fee for nonmembers is $10. For details eontact the Local Arrangements Committee, New York State Journal of Medicine, 750 Third Ave., New York 17.

Public Health Association to meet

The American Public Health Association will have its annual meeting along with those of about 60 related organizations at Detroit's Cobo Hall November 13-17. Registration will be open to nonmembers. Among those attending will be administrators, researeh seientists, and other specialists on the staffs of international, national, state and local health serviees, and voluntary agencies.

Scientific sessions and exhibits will cover eommunity health, prevention of disease, and control of environmental health faetors; and an opening symposium will diseuss Organization for New Responsibilities in Public Health. The Sedgwiek Memorial Medal, highest annual award in publie health, will be presented during the meeting.

For more details write the Ameriean Publie Health Assoeiation, 1790 Broadway, New York.

Increase AMA dues for 1962

Dues for active members of the Ameriean Medieal Assoeiation were increased to $35 for 1962 and to $45 for 1963, as reeommended by the Board of Trustees and approved by the House of Delegates at the annual meeting in New York. The present dues of $25 were established in 1950.

The additional ineome will be used to implement new and expanded programs:

1. New drug information program for M.D.'s.
2. A complete study of internships and residencies in relation to purposes of graduate medical education, its design and changes needed.
3. A study of approved internships, number of interns to fill them, and mechanisms for fulfilling service needs of hospitals without intern or resident staffs.
4. Medical recruitment program including financial assistance to medical students.
5. A program to combat mental illness.
6. Health and safety edueation program for the public.
7. International health program in eonjunetion with world medieal organizations.

Society for Crippled Children Meeting set

The 1961 eonvention of the National Society for Crippled Children and Adults will be held November 17-21 at the Denver-Hilton Hotel in Denver. Progress reports on research projeets sponsored by the Easter Seal Researeh Foundation will be featured, along with a talk by N. C. Kephart, Ph.D., professor of psyehology, Purdue University, on "The Brain Injured Child in the Classroom," and a workshop for members of the nursing profession.

Included in the researeh projects to be discussed are a study on architectural barriers to the crippled in public and private buildings and a pilot projeet on a new experimental leg-ankle brace.

Silver Cross Hospital Has refresher course

Silver Cross Hospital, Joliet, is sponsoring a refresher eourse on Eleetrolytes and Water Balance the mornings of October 11 and 18 in its Nurses' Home Auditorium. Subjeets and leetures Oetober 11 will inelude "Electrolytes and Fluid Balance in Post-Operative Patients," Dr. William Shoemaker, Chieago; "Electrolytes and Fluid Balanee in Renal Disease," Dr. David P. Earle, Chicago. On Oetober 18 "Eleetrolytes and Fluid Balanee in Diarrhea of Infants," and "Fluid Balance and Eleetrolyte Metabolism in the Newborn," Dr. Jack Meteoff, Chieago; and "Hyponatremia," Dr. John Fuller, Chieago.

All physieians are weleome; registration fee of $25 to the hospital should be mailed to Mr. Herbert Neff, administrative assistant.

PG courses

The five-part 1961 postgraduate courses sponsored by the Council on Postgraduate Medical Education of the American College of Chest Physicians began in July and continues on September 25-29 at the Warwiek Hotel in Philadelphia with a eourse in Industrial Chest Dis-

eases. It will be followed by Clinical Cardiopulmonary Physiology at Chicago's Sheraton Towers October 23-27.

Tuition to members of the ACCP is $75; to nonmembers $100. For more information write the American College of Chest Physicians, 112 E. Chestnut St., Chicago 11.

The American College of Physicians will present eight *Postgraduate Courses* through the fall and winter of 1961-62, beginning with "Changing Concepts of Cardiopulmonary Disease" September 18-23 at Ohio State University Health Center, Columbus.

Some of the other courses are "The Internist's Role in the Pre- and Postoperative Care of the Surgical Patient" November 6-10 at the Mayo Clinic, Rochester, Minn.; "Medical Genetics" January 29 through February 1 at the University of Michigan Medical School, Ann Arbor; "Pathologic Physiology of the Blood Dyscrasias" February 12-16 at Washington University School of Medicine, St. Louis, Mo.

To receive a program write the College at 4200 Pine St., Philadelphia 4.

A comprehensive review of clinical endocrine problems and current research activity in these areas will be presented at the *Postgraduate Assembly in Endocrinology and Metabolism,* under the co-sponsorship of the Endocrine Society and the National Institutes of Health, in Bethesda, Md., October 2-6. The fee for physicians will be $100, with a reduction to $30 for residents and fellows. Enrollment is 100 only.

Jottings on future meetings

The meeting of the Midwest Regional Group of the *Medical Library Association* will be in Rochester, Minn. on October 27 and 28. Any inquiries should be addressed to the chairman of the local committee, Mr. Thomas E. Keys, Librarian, Mayo Clinic, Rochester.

The *American Rhinologic Society* will have its annual meeting at the Belmont Hotel, Chicago, October 7, and will feature addresses on "Research and Education in Rhinology," "Upper Half Syndromes Associated with Nasal Pathology," "New England Pioneers in Rhinology," and "Medicine — A Dedication."

It will be preceded by a three-day seminar and workshop at the Illinois Masonic Hospital, a symposium on technics in nasal tip surgery.

There is no registration fee, and all physicians are invited to attend. For details write Dr. Robert M. Hansen, Secretary, 2210 Lloyd Center, Portland 12, Ore.

The *Colorado State Medical Society* and the *Congress on Occupational Health,* sponsored by the American Medical Association, will hold combined meetings at the Brown Palace and Shirley Savoy hotels in Denver October 1-4. The opening morning program will be given over to veterinary medicine with the afternoon program for general practitioners. Subjects to be discussed during the Congress program include diagnosis of occupational illness, relationship between the plant physician and the family physician, workmen's compensation, role of the occupational nurse, and the efficient utilization of the worker.

The *Western Institute on Epilepsy* will hold its annual conference October 11 through 14 at the Granada Hotel and Inn, San Antonio, Texas. According to the preliminary program, various aspects of epilepsy — clinical, biochemical, psychological and social, and electroencephalographic — will be discussed.

The *Illinois Nurses' Association* will discuss What Shall Tomorrow's Nurse Be Educated to Do? at its program meeting Thursday and Friday, September 28 and 29 at the Pere Marquette Hotel in Peoria. A purpose of the meeting is to help nurses understand what changes may be required in the Illinois Nursing Act to help upgrade nursing practice.

Mrs. Elizabeth K. Porter, immediate past president of the Ohio State Nurses' Association, will be the speaker at the Thursday dinner meeting. On Friday morning a panel of three nurse educators will discuss the two, three, and four year nursing education programs and the kind of nurse each is designed to graduate.

The *Annual Conference of the U.S. Civil Defense Council* will be held October 16-20 at the Hotel Ambassador in Los Angeles. There will be medical workshops on disaster and the physician's role in the community civil defense program, with emphasis on thermo-nuclear effects, radia-

tion, survival, shelters, and reactions in a disaster.

There will also be a three-day training course on "Decision Making in Emergencies."

Applications should be forwarded through appropriate civil defense channels to Director, Western Instructor Training Center, 620 Central Ave., Alameda, Cal.

The first national *Congress on Medical Quackery* will be at the Sheraton-Park Hotel in Washington, D.C., October 6-7. It is being sponsored by the department of investigation of the American Medical Association and the Food and Drug Administration. It is felt that the congress would be an effective way of spotlighting charlatans who thrive on an uninformed public.

The *Animal Care Panel's* annual meeting September 27-29 at the Statler Hilton Hotel, Boston, will present discussions on the production, care, and use of laboratory animals.

The meeting will be held in association with the American Board of Laboratory Animal Medicine, the Laboratory Animal Breeders' Association, and the Allied Trade Association.

Clinics for crippled children

October 4 Alton (Rheumatic Fever), Alton Memorial Hospital
October 4 Hinsdale, Hinsdale Sanitarium
October 4 Rock Island (Cerebral Palsy), Foss Home, 3808 — 8th Avenue
October 6 Chicago Heights (Cardiac), St. James Hospital
October 10 East St. Louis, St. Mary's Hospital
October 10 Peoria, Children's Hospital
October 11 Champaign-Urbana, McKinley Hospital
October 12 Cairo, Public Health Building
October 12 Flora, Clay County Hospital
October 12 Springfield, St. John's Hospital
October 13 Evanston, St. Francis Hospital
October 17 Belleville, St. Elizabeth's Hospital
October 17 Danville, Lake View Hospital
October 17 Quincy, Blessing Hospital
October 18 Chicago Heights (General), St. James Hospital
October 19 Elmhurst (Cardiac), Memorial Hospital of DuPage County
October 19 Rockford, St. Anthony's Hospital
October 24 Effingham (Rheumatic Fever), St. Anthony Memorial Hospital
October 24 Peoria, Children's Hospital
October 25 Elgin, Sherman Hospital
October 25 Springfield (P.M. — Cerebral Palsy), Memorial Hospital
October 26 Bloomington (A.M. — General) (P.M. — Cerebral Palsy), St. Joseph's Hospital
October 26 Mt. Vernon, Masonic Temple

Abdominal aneurysms

Perhaps the most important observation of all concerns the survival rate of patients having surgical therapy of abdominal aneurysms compared with the survival rates of patients who were treated medically for aneurysms. Sheranian, Edwards, and Kirklin pointed out a survival rate comparable with the figures of De Bakey and his associates of approximately 70 per cent survivors at the end of three years as compared to only 49 per cent survivors in Estes' group of medically treated patients at the end of three years. Certainly the lack of complications in late follow-up in all reported cases makes it all the more imperative that we reduce the number of patients coming to us with ruptured aneurysms or situations in which they have to be operated on as semiemergencies. It is apparent that early operation in the asymptomatic stage has the same importance in the field of aneurysmal surgery as it does in the field of cancer surgery. *James D. Moody, M.D. Late Results in Vascular Surgery. J. Florida M.A. April* 1961.

NEWS of the STATE

County News

Cook

New research building for University of Chicago

Groundbreaking ceremonies were held in August for the $2,971,000 six-story Philip D. Armour Clinical Research Building on the campus of the University of Chicago. The building, scheduled for completion in 1962, will be located



New Philip D. Armour Research Building

near the west side of Ellis Avenue and will run east and west to connect the Argonne and Billings hospitals at their north ends.

This newest structure in the University of Chicago hospital, clinic, and research complex is named in memory of a member of the Armour family of Chicago who died in 1958. It will be Gothic-style to match the rest of the university's campus and will house 51 laboratories, with a sub-basement for radiation therapy and radiology research adjoining supervoltage radiation therapy units in the Argonne Hospital, making it one of the most extensive in the United States.

Research activities will be conducted at the basement level in the department of ophthalmology, which recently developed new equipment to treat retinal detachment. On the first floor will be ear, nose, and throat research. A unique project of this laboratory has been the establishment of a temporal bone bank where ear bones donated to it are studied.

The second floor will be used to expand research activities of the Walter G. Zoller Dental Clinic. The third, fourth, and fifth floors will be devoted to surgery, a portion of the third floor to be occupied by neurosurgery. The top floor will be used for intern quarters.

Physician samaritan to Swaziland

On August 1 Dr. Howard H. Hamlin of Chicago left for Bremersderp in the British protectorate of Swaziland, South Africa, to help out in an understaffed hospital there operated as a mission by the Church of the Nazarene, giving up his vacation to do so. A story in the Chicago Tribune on Dr. Hamlin's plans and the hospital's urgent need for trained medical personnel resulted in dozens of calls from physicians, nurses, laboratory technicians, x-ray technicians, and social workers offering to go along and help.

He was amazed and gratified, especially since "They know they'd get no money and would have to pay their own expenses." Although he couldn't accept their offers immediately because of unfamiliarity with the exact needs of the hospital, he took all their names with the hope of setting

up a rotating plan for keeping the hospital staffed.

The hospital has 225 beds and is the best equipped in its area; but its normal staff is only five physicians—one of whom retired recently, while another is on furlough. By comparison, South Shore Hospital, where he is on the staff, has 175 beds and 75 doctors.

Dr. Hamlin, who is a member of the foreign missions department of the Church of the Nazarene, was accompanied by his son, Mark, 16, and Kent Moore, 18, son of the Rev. Mark Moore, superintendent of the Chicago central district of the Church of the Nazarene. Both boys want to be doctors and have been working as orderlies in the South Shore Hospital to train for their jobs in Swaziland. This year they'll spend only four weeks there but next year hope to stretch it to two months.

Dr. Hirsch honored

A reception and testimonial dinner honoring Dr. Edwin F. Hirsch at the time of his seventy-fifth birthday was held at the Drake Hotel August 19. Friends, associates, and former students came to do him honor.

Dr. James H. Hutton, Chicago, served as master of ceremonies at the dinner. Speakers were representatives from medical groups with which Dr. Hirsch has been associated in his long career:

Chicago Medical Society—Dr. T. R. Van Dellen
Illinois State Medical Society—Dr. George F. Lull
Institute of Medicine of Chicago—Dr. H. T. Ricketts
(Old) St. Luke's Hospital—Dr. Howard Wakefield
Columbus Hospital—Dr. Ernest Nora
Former residents representatives—Dr. Russell Morgan, Johns Hopkins University

A bound volume of congratulatory letters was presented to Dr. Hirsch by Dr. Frederick Bauer, Silver Cross Hospital, Joliet, chairman of the committee that planned the occasion.

The JOURNAL adds its congratulations. Dr. Hirsch has been on the Editorial Board since 1950, and chairman since 1958.

Among his services for the Society that date back to 1944 is his chairmanship of a committee, variously named, to study the position of coroner; through this committee he was instrumental in upgrading the office of coroner.

He is presently chairman of the Committee on Forensic Medicine.

Cardiovascular research center

A new center for research in heart disease will be set up at Michael Reese Hospital and Medical Center under a five-year grant of almost $1.4 million from the National Heart Institute, a division of the United States Public Health Service.

The Cardiovascular Center, under the direction of Dr. Louis N. Katz, head of the cardiovascular department, will use the funds for three major areas of heart research: atherosclerosis, hemodynamics, and electrocardiography. Adult cardiac patients will be selected on a voluntary basis and will receive treatment without cost; healthy adults may also take part to supply information on the normally functioning heart.

Four beds in the Main Michael Reese Building will be used for the patients, who will be closely studied by clinicians and medical scientists on the staff.

The heart station, presently used for electrocardiography, cardiac catheterization, and other diagnostic studies, will be enlarged and new equipment installed when it moves to the nearly completed Jennie M. Kaplan Surgical Wing.

The grant will enable a shift in emphasis from animal research to the observation and study of human patients, with the application of methods already proved safe in the laboratory.

Student award

Mr. Julian Katz of New Jersey, a third-year student at the University of Chicago, Division of the Biological Sciences, received a $600 Burroughs Wellcome Summer Scholarship for 8 to 12 weeks of supervised training and experience in clinical and research allergy from the Allergy Foundation of America. The awards are given to twenty-one medical students from medical schools throughout the United States and Canada. Mr. Katz has been working under the guidance of Dr. Harold Goodman, research associate, Allergy Laboratory of the department of medicine at the University of Chicago, on inhibition of the immune response in adult animals.

Awards

Dr. Charles Huggins, director of the Ben May Laboratory for Cancer Research at the University of Chicago, will go to London in October to receive the Walker Prize from the Royal College of Surgeons of England, given once every five years for the best work in cancer research in the preceding five years. Co-recipient is Dr. Ludwik Gross, chief of cancer research at the Veteran's Administration Hospital in New York City. Both physicians will receive 100 pounds sterling and official scrolls from the college.

Dr. Huggins is being honored specifically for sustained and distinguished contributions to cancer research, particularly in the field of endocrine physiology.

Dr. Huggins is an honorary fellow of the Royal College of Surgeons, of Edinburgh and London, and a member of the National Academy of Sciences. He has been a professor at the University of Chicago since 1937 and director of the Ben May Laboratory since 1951.

Grant to study action of histamine

The Atomic Energy Commission has granted over $51,000 for a three-year continuing study, subject to yearly approval, of the action of histamine in the human body to Dr. Spyridon Alivisatos, academic associate at Mount Sinai Hospital. He has isolated a substance which may be the product of the harmful action of histamine in the body. The research now is concerned with the reasons for the release of histamine from certain cells, its presence, and why it is harmful.

LaRabida Sanitarium to care for arthritics

LaRabida Sanitarium in Jackson Park has recently expanded its medical program to include the care of patients with rheumatoid arthritis and related diseases. New facilities have been created for physiotherapy and physical rehabilitation for patients up to 18 years old. They will permit complete management, including bed care for acute attacks and long term outpatient follow-up with supervision of physical therapy and aid in social adjustment.

In cooperation with the Division of Vocational Rehabilitation of the State of Illinois, it has inaugurated a program for guidance in job selection and training consistent with the patient's physical ability.

Basic research programs on rheumatic diseases are being conducted by the LaRabida-University of Chicago Institute in the Variety Club Research Center in the Richard J. Finnegan Memorial Building.

Appointments

Col. Warner F. Bowers, MC, U.S. Army, retired, Chicago, has been appointed assistant executive director of the International College of Surgeons. He will be coordinator of educational programs, including the scientific programs for the college's state, regional, federation, and international congresses.

Col. Bowers, who received his M.D. from the University of Nebraska Medical School in 1932, was chief of the department of surgery at Tripler U.S. Army Hospital in Honolulu from 1956 until his recent retirement. Before that he was commanding officer of the Army Hospital at Camp Phillips, Kansas; chief surgical consultant at General MacArthur's Headquarters, Far East; chief of surgery at Tokyo Army Hospital; and from 1948 to 1952 was chief surgical consultant to the Office of the Surgeon General of the Army, attending military hospitals in Europe, the Far East, Panama, and the continental U.S.

Appointments of five new faculty members and the promotion of nine other physicians in the Northwestern University Medical School have been announced.

The new medical faculty members, all with the rank of assistant professor, are Drs. Jack D. Armold, Chicago, orthopedics; Leslie B. Reynolds, Des Plaines, physiology; William L. Riker, Winnetka, surgery; Irwin Schultz, Chicago, microbiology; and Virginia S. Tarlow, Winnetka, neurology and psychiatry.

Physicians promoted to full professors were Samuel M. Bluefarb, Chicago, dermatology, and Allen Lein, Evanston, physiology.

Promotions to associate professors include Drs. Marvin Cornblath, Glencoe, pediatrics; David W. Cugell, Chicago, medicine; John T. Grayhack, La Grange, urology; Anna Hamann, Chicago, radiology; George C. Henegar, Chicago, surgery; Julius B. Kahn, Jr., Winnetka, pharmacology; James W. Linman, Wilmette, medi-

cine; Stephen E. Reid, Evanston, surgery; E. Clinton Texter, Kenilworth, medicine; and Sheldon S. Waldstein, Glencoe, medicine.

Dr. Grayhack was also made chairman of the department of urology.

Dr. Joseph R. Christian, professor at the University of Illinois College of Medicine, has been made full-time chairman of the department of pediatrics of Presbyterian-St. Luke's Hospital. He is professor of pediatrics at Loyola University's Stritch School of Medicine, where he was a graduate, and chairman of the pediatric department, Mercy Hospital. He is also senior attending pediatrician at Cook County Hospital and has been chief of pediatrics at Lewis Memorial Hospital since 1951.

He is a fellow of the American College of Physicians, American Academy of Pediatrics, American College of Chest Physicians, and the American Public Health Association. In 1954 and 1957 he received Loyola's Student Clinical Faculty Award.

Walter James McNerney, director of the Bureau of Hospital Administration, School of Business Administration of the University of Michigan, assumed the presidency of the national Blue Cross Association in August, succeeding James E. Stuart, now chairman of the association's board of governors.

Mr. McNerney was an assistant professor of hospital and medical administration at the University of Pittsburgh from 1953 until 1955, when he left to establish the hospital administration program at the University of Michigan. In 1958 he became director of the bureau there.

Hospital's "Promise"

Presbyterian-St. Luke's Hospital was the subject of a Saturday supplement section titled "Promise" in the Chicago Daily News in June. The Woman's Board of the hospital contributed their services in compiling the magazine, which was devoted to portraying teaching, service, and research facets of the hospital, along with its goals or "promise" for the future.

Proceeds from advertising space in the supplement went to help support the free care and education program in effect at Presbyterian-St. Luke's.

Lake

Hospital wing dedicated

On August 20 the new South Wing of Highland Park Hospital was dedicated, and by early fall all work on the expansion program begun in 1958 at a cost of $2,750,000 will be finished.

Added also to the hospital were a professional services wing, along with extensive remodeling of its older sections. Among major departments and services to be relocated to modernized and enlarged sections are emergency and outpatient service, obstetrical, pediatric, and administrative departments. The hospital now has nearly 200 beds.

The Medical Pavilion, located about a mile from the hospital and acquired in 1956, will be put up for sale.

St. Clair

Dr. Arnold Moe, East St. Louis, has become editor of the St. Clair County Medical Society Bulletin, filling the post left vacant by Dr. Dale Rosenberg, who is on a two-year residency in Honolulu.

General News

Legislative review

In July Gov. Kerner signed into law the following House Bills:

Bill 625—$74,900,029 to the Department of Public Welfare for permanent improvements at state owned public welfare institutions.

Bill 626—$2,929,920 to the Department of Public Welfare for architectural and engineering fees for permanent improvements at state owned public welfare institutions. It took effect at once.

Bill 651—$12,825,000 to the Department of Public Welfare for permanent improvements at state owned public welfare institutions. It went into effect immediately.

Bill 1411—Requires referendum approval before issuing bonds in sanitary districts to provide drainage and sewage disposal. Effective January 1, 1963.

Bill 1464—$47,844,891 to the Department of Public Welfare for the construction of hospital clinics and the acquisition of clinic sites.

Dr. Yoder appointed director of state Health department

Dr. Franklin D. Yoder, a member of the executive staff of the American Medical Association since 1959, became director of the Illinois Department of Public Health on September 1. A native of Cheyenne, Wyo., he has been the



Dr. Franklin D. Yoder

AMA's director of the Division of Environmental Medicine and acting director of the department of international health.

Dr. Yoder received his B.S. and M.D. degrees from Northwestern University Medical School and after two years of general practice in Cheyenne, a masters degree in public health administration from the University of California. He is a diplomate of the American Board of Preventive Medicine.

From 1948 to 1959 he was director of the Wyoming Department of Public Health. He was secretary-treasurer of the Association of State and Territorial Health Officers from 1954 to 1956 and served as president in 1957. He was also a member of the United States delegation to the World Health Organization in 1957.

Congratulations, Dr. Yoder.

Physicians endorse insurance claim forms

Approximately 1,000 physicians requested more standardized health insurance claim forms following the initial mailing as first announced in the June issue of the Illinois Medical Journal. The large number of requests for more forms is indicative of the widespread desire among physicians to curtail the paper work involved in processing health insurance claims. Several county societies have announced formal endorsement of the use of these forms by their members.

Under the program Illinois physicians will insist that insurance companies use the standardized claims forms developed in conjunction with the Health Insurance Council and easily identified by the Health Insurance Council (HIC) symbol. The recommended procedure is as follows:

1. When presented with a claim form identified by the HIC symbol, fill it out and return it to the insurance company.
2. When presented with a claim form that is not identified by the HIC symbol, fill out one of the standardized forms, clip it to the unacceptable blank form, and return both forms to the insurance company.
3. If the insurance company insists on having a form completed which does not bear the HIC symbol, a reasonable charge for completing a nonstandard form is justified.

The standardized form, now being distributed from the headquarters office in pads of 50, is a special combination form (HIC Comb-1) suitable for both group and individual claims.

In expressing warm praise for this project as a service to the membership, one physician writes (in part)

"The variety of forms is bewildering and still keeps increasing. One member cannot do much about it; he (or she) has to comply or risk nonpayment for a justified claim. If all members of the Society would voluntarily follow the chairman's suggestion, this should help considerably, reducing the variety of forms. The benefits to the membership would be immediate and unquestionable."

Dr. James A. Campbell, chairman of the Division of Medicine, Presbyterian-St. Luke's Hospital, Chicago, in a letter to Dr. Piszczek, our Society's Council chairman, says,

"May I say that I am extremely pleased with your simplified claim forms. I think that you and the Society are to be commended, and I hope that this will prove a very important addition to assistance in the incredible amount of paper work forced upon physicians."

It is not envisioned that physicians will need to stock a large supply of the HIC forms once it becomes known that physicians in Illinois expect insurance companies to use the forms developed and approved by their own industry.

Requests for forms should be addressed to the Society at 360 N. Michigan Avenue, Chicago 1.

Governor calls for equality under law

Gov. Otto Kerner recently issued an executive order to all departments, commissions, and agencies of state government concerning the Fair Employment Practices bill which he signed in July. The bill creates a commission to reduce denial of equality of employment opportunities because of race, color, religion, national origin, or ancestry.

In his order the governor reminded state departments, political subdivisions, and municipal corporations that suppliers, contractors, and labor unions providing goods or services must obey the Fair Employment Practices law provisions.

Dr. Hyde to direct new AAMC division

The Association of American Medical Colleges has chosen Dr. Henry van Zile Hyde, assistant to the Surgeon General for International Health and chief of the Division of International Health, U.S. Public Health Service, to head its new Division of International Medical Education. Dr. Hyde will be responsible for the development and operation of the division, which is being established with Rockefeller Foundation funds.

The Division's aim is to promote interest in international cooperation in medical education; develop a coordinated plan to assist various agencies in recruiting American faculty for service abroad; assist overseas faculty to locate temporarily in this country; contribute to improved educational opportunities for foreign graduates seeking advanced clinical and research training in the U.S.; and conduct forums for the exchange and discussion of information and ideas.

Dr. Hyde is the U.S. member of the Executive Board of the World Health Organization and has been since its inception by appointments from Presidents Truman, Eisenhower, and Kennedy. He has also been a member of the U.S. Delegation to each of WHO's 14 World Health assemblies. He has served on the faculties of Rochester and Syracuse universities, Albany Medical College, and the schools of public health at Harvard and Johns Hopkins.

Deaths

John J. Belensky, Chicago, a graduate of the Stritch School of Medicine of Loyola University, then Loyola University School of Medicine, in 1917, died July 19, aged 65. He was senior staff member of St. Elizabeth Hospital, a physician on the Northwest Side for over 40 years, and a veteran of World War I.

John A. Bondzinski, Chicago, a graduate of the Rush Medical College in 1920, died July 12, aged 66. He was senior staff officer at St. Bernard Hospital and had practiced for more than 40 years in the Chicago area. He was a past president of the Englewood branch of the Chicago Medical Society and had lectured many years at Loyola University School of Medicine.

Joseph H. Garthe*, Rockford, a graduate of the Stritch School of Medicine of Loyola University, then Loyola University School of Medicine, in 1931, died July 23, aged 55. He was certified in pediatrics in 1942 and was an attending pediatrician at St. Anthony Hospital in Rockford. He was also on the courtesy staffs at Rockford and Swedish-American hospitals there. In World War II he was a major in the Army Medical Corps and was a fellow in the American Academy of Pediatrics and a former member of the boards of directors of the Winnebago County Mental Health Society and of the Family Consultation Service.

John I. Gross, Chicago, a graduate of the University of Chicago School of Medicine in 1954, died July 20, aged 37. He was a staff member of the pediatrics department at the University of Chicago and the Bobs Roberts Hospital on the campus and was an instructor at LaRabida Sanitarium in Jackson Park. In 1959 he won an award from the Interstate Postgraduate Medical Association for his research in metabolism.

Ralph C. Hamill*, retired, Winnetka, a graduate of the Rush Medical College in 1902, died

July 5, aged 84. He was a former president of the Illinois Society for Mental Hygiene, and in 1949 was awarded an honorary vice presidency by the group for his work in behalf of mental health. At one time he had studied psychiatry under Sigmund Freud in Europe before returning to specialize in nervous disorders, practicing in Chicago for 52 years before retiring five years ago. He had taught at Northwestern University Medical School and Rush Medical College and had been on the staffs at Henrotin and Hines Veterans hospitals.

Otto W. Konzelman*, retired, Chicago, a graduate of the Barnes Medical College, St. Louis, in 1899, died July 8, aged 84. He was medical director of Walther Hospital until the time of his death and a counselor of the Northwest Branch of the Chicago Medical Society. He was active in Masonic affairs and a member of Medinah Temple. He had practiced in Chicago over 50 years until his retirement a year ago.

William R. Larkin*, retired, Cicero, a graduate of the University of Illinois College of Medicine in 1908, died July 16, aged 81. He was former chief of the medical staff at the former University Hospital and later had been on the staff at Columbus Hospital. He did graduate work in Edinburgh, Vienna, Berlin, and Paris. He retired from practice three years ago.

Lawrence J. Lawson*, Evanston, a graduate of the Rush Medical College in 1922, died July 11, aged 65. He was a former president of the North Suburban Branch of the Chicago Medical Society, past president and secretary-treasurer of the Chicago Laryngological, Rhinological, and Otological Society, and past president of the University Club of Evanston.

He was head of the department of otolaryngology at Evanston Hospital and for 25 years was assistant professor of otolaryngology at Northwestern University Medical School, last year receiving its Alumni Association Award for his many years of service. He was a fellow of the American College of Surgeons, a member of the American Academy of Otology and Ophthalmology and the Pan American Association of Ophthalmology, and was a certified ophthalmologist.

Francis M. Link*, Paris, a graduate of the Rush Medical College in 1901, died June 2, aged 81. He had practiced in Paris for almost 60 years and in 1953 was honored by the Edgar County Medical Society for his 50 years as a physician. In 1955 he was honored by Edgar County citizens who cited his services to the community and his profession. In 1952 he was chairman of the Edgar County Health Council.

Dimetrus J. Louis*, Chicago, a graduate of the Emory University School of Medicine, Atlanta, in 1917, died July 21, aged 72. He operated the Louis Clinic in Chicago and had been a consulting physician for the Illinois Central Railroad for 40 years.

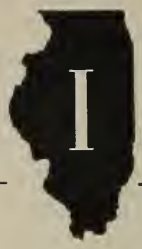
Joseph E. Schaefer, retired, Chicago, a graduate of the Rush Medical College in 1924, died June 29, aged 76. He was chief of oral and plastic surgery at Cook County Hospital and professor of oral surgery at Northwestern University Dental School until he retired four years ago. He was also a former member of the Wesley Memorial Hospital staff and a former consulting oral surgeon at Henrotin Hospital. He was a member of the Illinois Athletic Club.

William H. Smith, Benton, a graduate of the National University of Arts and Sciences Medical Department, St. Louis, in 1894, died June 25, aged 97. He had practiced in Benton from 1895 until last year and had served as a representative in the state legislature for two terms in the early 1900's. He was a member of the 50-Year Club of the Illinois State Medical Society. For a time 57 years ago he was house physician at the Menard Prison and had been a member and president of Benton's school board.

**Indicates member of Illinois State Medical Society.*

Tolerance is the positive and cordial effort to understand another's beliefs, practices and habits without necessarily sharing or accepting them. — *J. L. Liebman*

BOOK REVIEWS



Current Therapy — 1961. Edited by Howard F. Conn, M.D. $12.50 Pp. 806. Philadelphia, W. B. Saunders Company, 1961.

This is the thirteenth annual edition of a well-known work whose editor and nine of its twelve consulting editors have served continuously since 1949. It is, however, essentially a new book, for 82 per cent of the 307 articles are, for the most part, newly written by a different list of authorities. This book is intended as a source to be utilized "only when a thorough and thoughtful diagnosis has been accomplished, and only when an effort has been made to visualize the nature of the disease process and the general measures required to combat it." The book capably provides a useful service to the busy practitioner by providing expert consultations on specific medical problems and their most effective methods of management. Most contributors have adopted a conservative approach and avoid undue emphasis on relatively new and inadequately evaluated agents or methods.

The format of the previous edition has been maintained, with division into 16 sections roughly corresponding to body systems and disease categories. In addition to the extensive replacement of previous subjects, new articles include discussions of cardiac arrest, pseudomembranous enterocolitis, cancer of the skin, an expanded coverage of strokes and a listing of poison control centers in the United States and Canada. The articles are written clearly and concisely and are logically organized with frequent short introductions concerning etiology, manifestations and prognosis, in addition to listing recommended therapeutic approaches. In some instances more than one method for treating a single disease has been listed, but instances of disagreement among physicians as to the selection of drugs or dosages are inevitable. As an aid to treatment following the establishment of a correct diagnosis, this book can be highly recommended as an authoritative guide to up-to-date therapeutics.

Sumner C. Kraft, M.D.

Key and Conwell's Management of Fractures, Dislocations and Sprains. H. Earle Conwell, M.D., and Fred C. Reynolds, M.D. $27. Pp. 1153. St. Louis, The C.V. Mosby Company, 1961.

The seventh edition of Key and Conwell's *Management of Fractures, Dislocations and Sprains* has a new co-author in Dr. Fred C. Reynolds, professor of orthopedic surgery at Washington University School of Medicine. This standard reference book on the care of fractures, dislocations, and sprains has been revised and brought up-to-date and parts of it rewritten. It is still the outstanding work that it always has been, and the revisions have brought the current methods of treatment into focus, although the general approach of the book is that of conservative management.

The book is divided into two main sections: First, principles and general aspects of treatment; second, diagnosis and treatment of specific injuries. The section on fractures of the jaw and facial bones has been re-written by Dr. James Barrett Brown and Dr. Minott Fryer. The section on hand injuries has been re-written by Dr. Arthur H. Stein, Jr.

The book is complete in all aspects of conservative and operative management of fractures and dislocations. It is of value to orthopedists as

well as general practitioners of medicine who are occasionally called upon to treat skeletal injuries.

William A. Larmon, M.D.

Intra-Abdominal Crises. Kenneth D. Keele, M.D., and Norman M. Matheson, F.R.C.S. $10. Pp. 411. Washington, Butterworth & Co., Ltd., 1961.

The objective of Kenneth D. Keele and Norman Matheson has been to analyse the problem of acute cases of abdominal pain and vomiting and to indicate the lines of early management.

The book is well organized, well written, and fairly complete. It is written for the doctor in practice. Some of the proprietary drugs mentioned are not commonly used in the United States.

It will find it's chief value in the library of the general practitioner who is looking for a quick guide to diagnosis and presurgical treatment of patients having abdominal pain and vomiting.

R. K. Gilchrist, M.D.

An Atlas of Acquired Diseases of the Heart and Great Vessels. Vols. I, II, and III. Jesse E. Edwards, M.D. $70. Pp. 1401. Philadelphia, W. B. Saunders Company, 1961.

Space will not permit an adequate review of these three volumes dealing with acquired diseases of the heart and great vessels. The author, Jesse E. Edwards, a Mayo Clinic pathologist, has the qualifications and experience to compile an atlas of this stature. These volumes represent 14 years of observation in this field.

Dr. Edwards correlates the *pathologic, physiologic, roentgenographic, electrocardiographic,* and *clinical* findings of hundreds of well studied patients who died from cardiovascular disease. There are no duplications, and material pertinent to the subject is included. Terms are defined; the gross and microscopic pathology is described and well illustrated, and the material is well organized. In Volume I the author concentrates on the diseases of the valves and pericardium. He begins with rheumatic carditis and ends with conditions functionally similar to chronic pericardial disease (a case of amyloidosis). Volume II is the largest of the three and includes coronary arterial disease, systemic hypertension, myocardial disease, the heart in systemic disease, and cor pulmonale. The diseases of the great vessels are discussed in Volume III.

This material will be of educational value to the medical student and enlightening to the general practitioner, internist, cardiologist, and pathologist. It is well indexed and can be used as a reference. The three volumes are expensive but worth it.

T. R. Van Dellen, M.D.

Essential Hypertension; an International Symposium. Edited by K. D. Bock and P. T. Cottier. $9. Pp. 392. Berlin, Springer-Verlag, 1960.

This report of a symposium held in Berne, Switzerland, between the 7th and 10th of June, 1960 should not be relegated to the library shelf, like so many reports of proceedings of meetings, for reference use alone; rather it should be read as a concise summary of the latest work on the possible relationships existing between so-called "essential" hypertension and salt and water metabolism. It also surveys the success of prevailing therapy used in the long term management of the patient with hypertension.

Although more than fifteen books have appeared within the last decade on the general subject of hypertensive disease, this volume provides essential up-to-date information on developments, not readily available elsewhere in this rapidly advancing field, of interest to internists, cardiologists, and other specialists in cardiovascular disease. The panel of some forty specialists from twelve different countries of both Western and Communist worlds were admonished to "banish all preconceived notions and beware of allowing ourselves to be blinded by questions of dogma, prestige, and personal pride . . . ensure that results should be compared, opinions exchanged and trends in research defined periodically on an international plane . . . As men of science . . . have no need to concern ourselves with the battles waged in the field of international politics . . . [but] seek to reconcile our views here in a spirit of understanding and open-mindedness." They have performed admirably as the original papers and abstracts of discussion show. The opposing views of these world authorities are exposed with candor through free interchange of opinion and observations and show not only

the reasons for a difference of opinion, but also the fundamental agreements that might otherwise be concealed by superficial inconsistencies.

Although no attempt is made to cover the field of hypertension comprehensively, the most significant features are handled remarkably well. The book begins with the "mosaic" of etiologies of hypertension, as it is called by Page — neural, endocrine, cardiovascular and renal — to contrast with the apparent singular etiology of infectious disease, a concept dominating clinical thought until recently. The nature of hypertension, benign and malignant, its natural course, relationship to kidney and endocrine system, and salt and water metabolism are thoroughly considered and lead logically to a long section on treatment. The pharmacology and dynamics of action of the various drugs used for the treatment are clarified by selected experiments reported from animal research. Experience with prolonged treatment of spontaneous hypertension in man is reported in detail. Prevention of the usual complications of hypertensive disease occupies the book's final section.

During the symposium reported, only two sessions were public so that the participants were given an optimal atmosphere for frank exchange of views — views sometimes diametrically opposed. This volume represents the best key available for revealing the concepts of these world-famous participants.

William H. Wehrmacher, M.D.

The Practical Application of Medical and Dental Hypnosis. Milton H. Erickson, M.D., Seymour Hershman, M.D., and Irving I. Secter, D.D.S. $12.50. Pp. 470. New York, The Julian Press, Inc., 1961.

This book is a compilation of tape recordings of a large series of seminars on hypnosis that were conducted by the authors in the past decade. Drs. Erickson, Hershman, and Secter are careful in stating that all of these sessions were held only under the auspices of various approved professional and scientific societies and universities in this country. This final product then is considered the official textbook of the Seminars on Hypnosis Foundation, which conducts regular sessions throughout the land on a postdoctoral level for groups of physicians, dentists, and psychologists who enroll for the course. The reviewer and many others in the disciplines of neurology and psychiatry have received regular notices for these seminars on many occasions.

There are 11 chapters in all. In the first chapter the authors utilize but a few pages for history and past development, less than a page on current status of hypnosis, and a few more pages on theory. The next 10 chapters deal with Suggestion and Hypnotizability, The Phenomena of Hypnosis, Induction Techniques, Clinical Applications in Surgical Anesthesia, Hypnosis in Obstretrics, Hypnosis in Children, Clinical Application of Hypnosis to General Medicine, Clinical Applications of Hypnosis to Psychiatry, Hypnosis in Dentistry, and Hypnosis in Psychology.

There is the attempt then, by the writers, to portray in simple and clear form the techniques of hypnosis. Certainly this book could hardly be expected to give clear and sensible advise on how to understand and how to use hypnotic therapy in clinical work nor even to practice hypnosis. Certainly after digesting this book, one could not expect to become a hypnotist, nor will the descriptions of practical techniques eliminate the dangers and the pitfalls so regularly encountered. Also the inexperienced technician can hardly be expected to know of the dangers and complications of perverse motivation in both patient and therapist. Finally the reviewer must emphasize again that in spite of the completeness and reliability of the contents of this book, that hypnosis is a psychological technique which should be utilized by only those who are qualified.

Louis D. Boshes, M.D.

Nothing in progression can rest on its original plan. We might as well think of rocking a grown man in the cradle of an infant. — Burke

PROCEEDINGS

1961 HOUSE OF DELEGATES

of the

ILLINOIS STATE MEDICAL SOCIETY

May 14-18, 1961
Sherman Hotel
Chicago, Illinois

FIRST SESSION

Sunday, May 14, 1961

The first meeting of the House of Delegates of the Illinois State Medical Society convened at 7:40 p.m. in the Louis XVI Room of the Hotel Sherman, Chicago, Illinois, with the President, Dr. H. Close Hesseltine, presiding.

The minutes of the 1960 meetings of the House of Delegates as published in the Illinois Medical Journal were approved.

PRESIDENT HESSELTINE: Gentlemen, during the year courses of events take their places. One of these is the tragic things of life. During the year we invariably lose a few members. During this past year we lost two past presidents, Dr. Joseph O'Neill and Dr. R. R. Ferguson.

It has been said that, "He has achieved success who has lived well, laughed often and loved much; who has gained the respect of intelligent men and the love of little children; who has filled his niche and accomplished his task; who has left the world better than he found it, whether by an improved poppy, a perfect poem or a rescued soul; who has never lacked appreciation of earth's beauty or failed to express it; who has always looked for the best in others and given the best he had; whose life was an inspiration; whose memory is a benediction."

Will you please stand in silent tribute.

(The members arose and observed a minute of silence.)

Dr. George F. Lull, President of the American Medical Education Foundation, and Dr. Arkell M. Vaughn, Illinois Chairman for AMEF, presented checks to the Illinois medical schools.

DR. LULL: First, before I award any of these, I would like to tell you that during the year the AMEF has collected one million, one hundred seventy-two thousand six hundred dollars. This is a six per cent increase over the previous year.

Now you may see some figures which show that the last year's collection was slightly above this, but the last year, the last fiscal year, had thirteen months in it, so that for a twelve-month period, this is a six per cent increase and in ten years the doctors of the United States have given to their medical schools ten million two hundred forty-seven thousand one hundred twenty-five dollars.

To Dr. Andrew H. Ryan, The Chicago Medical School. The amount of the check is twenty five thousand eight hundred seventy-nine dollars. This makes a total in the last five years of one hundred twenty-six thousand seven hundred seventy-seven dollars, and in addition to this, the voluntary giving from alumni, not included in this, is an additional seventy-eight thousand seventy-seven dollars.

The AMEF, in addition to furnishing this money to medical schools, has throughout the country stimulated the giving of alumni directly to the schools.

DR. RYAN: On behalf of the Board of Trustees of the Chicago Medical School, I thank the Illinois State Medical Society and Dr. Lull for this generous contribution to our medical program.

DR. LULL: To Dr. Richard H. Young, of the Northwestern University Medical School: your check this year amounts to thirty-five thousand seven hundred thirty-seven dollars, which totals in the last five years one hundred seventy thousand six hundred forty-eight dollars.

Now in addition to this, the Northwestern University Medical School has received ninety-two thousand ninety-two dollars from alumni to direct giving.

DR. YOUNG: On behalf of Northwestern University Medical School, I wish to express my appreciation to all of you. This represents the interest on about eight hundred thousand dollars in endowments and such non-restricted funds are the lifeblood of any medical school, I assure you.

DR. LULL: Dr. John S. Sheehan of Stritch School of Medicine, Loyola University, the check for the Stritch School of Medicine is twenty-six thousand four hundred seventy-four dollars. This totals in the last five years one hundred thirty-four thousand seven hundred thirty-one dollars, and in addition they have received one hundred twelve thousand eight hundred forty-seven dollars from direct giving.

DR. SHEEHAN: On behalf of the Stritch School of Medicine, I want to echo the same sentiments as Dr. Young. I can't calculate that fast how much interest this would be in endowments, somewhere around one hundred fifty thousand dollars.

I would like to correct one figure. We are on two different years as far as calculating the amount of money given by the alumni. You are on a calendar year and we are on the fiscal year beginning July 1, and therefore, our figure from our alumni was one hundred forty thousand dollars, and we are sincerely grateful to you for the support you have given us.

DR. LULL: I have been asked the amount given by Illinois physicians to these schools. It comes to one hundred ninety-nine thousand eight hundred forty-three dollars.

Now you know, many people, many members do not earmark their gifts, but these are earmarked gifts, I believe, one hundred ninety-nine thousand dollars.

To Dr. Page of the University of Chicago School of Medicine, a check for the University of Chicago School of Medicine amounting to twenty thousand five hundred seventy-one dollars, a total in the last five years of one hundred seven thousand five hundred two dollars. And in addition, voluntary giving, direct, thirty-five thousand nine hundred fifty-nine dollars.

DR. PAGE: I am very happy to accept this check on behalf of Dr. Bennett who couldn't be here tonight and the University of Chicago. Thank you very much.

DR. LULL: The final one is to Dr. Granville A. Bennett of the University of Illinois College of Medicine. Dr. Bennett, your check is for thirty-two thousand nine hundred eighty-seven dollars, which brings your five-year total to ninety-three thousand four hundred fifty-one dollars, and the voluntary giving aside from this amounted this year to sixteen thousand seven hundred sixty-two dollars.

DR. BENNETT: Thank you, Dr. Lull. Members of the Association, I would like to express on behalf of the University of Illinois our sincere gratitude to the AMEF for this most generous contribution.

Like Dr. Young said, even in the state universities these fluid funds are terribly important. Thank you very much.

Dr. Hesseltine introduced the honorary delegates from the Student American Medical Association.

From the Chicago Medical School, Mr. Laurence Seigler, Mr. John M. DuManis.

From the Northwestern University Medical School, Miss Sandra Jane Forbes.

From Stritch School of Medicine, Joseph DeFiore and John Belmonte.

From the University of Chicago, Robert Ridley and Edwin Rosenblum.

From the University of Illinois College of Medicine, John R. Shepherd and David Pogue.

Dr. Hesseltine introduced Dr. William E. Carnahan, elected Physician of the Year in Illinois, and Mrs. Carnahan. They were escorted to the platform by Fred C. Endres, Councilor from the Fourth District, and Dr. V. B. Adams, delegate from McDonough County.

PRESIDENT HESSELTINE: On behalf of all of the members of our Society, it is a pleasure to welcome you, Dr. Carnahan and Mrs. Carnahan to this podium.

You have read and known some of the reasons for your selection. One is you have been active in our county medical society, you have been chief of staff, both of Dunbar County and St. Francis Hospitals. You have been in the practice for more than forty years.

There are an innumerable number of things for which we can be proud of you and I am sure your family, patients and friends have paid tribute to you for it.

Suffice the amenities to simply give you this certificate

which designates you as the outstanding practitioner of Illinois for 1961.

DR. CARNAHAN: Somehow, I would have felt better if the lights had been on you in place of me.

But of course, there are certain things in life we have to put up with and that was one of them.

I haven't any doubt at all but that everybody who is here has had some special occasion in his life for which he has had no words with which to describe his appreciation.

This is one of mine.

I have had honors given me before, but never anything to equal this. The Medical Society of Illinois has just honored me as being the outstanding family physician of the state. That means a great deal to me because of the fact that this State Society is one of the great societies in the United States of its type. It includes in its membership some of the greatest teachers, greastest scientists, as a matter of fact, some of the greatest minds in every branch of public health today.

Not only that, but it has in its numbers a great many of those dedicated, sincere individuals, both men and women, that we call the general practitioners. I am proud to be classed with them. I have always been proud of being a general practitioner.

I appreciate this from our State Society, but I would be definitely remiss if I did not express also my sincere appreciation to my own county medical society.

This has come basically from them, from those people who know you best, who know your weaknesses as well as your few strengths and your few virtues.

In spite of that, they chose me as their representative. I want to sincerely thank them.

I want to sincerely thank the State Medical Society for this wonderful honor that has been given me.

Secretary Reisch assigned the following resolutions which arrived too late for inclusion in the handbook to reference committees.

Macon County Medical Society
Hospital Utilization No. 32

WHEREAS, a conference on hospital utilization was conducted jointly by the Illinois Hospital Association and the Illinois State Medical Society in Springfield on Wednesday, April 19, 1961, and

WHEREAS, the Macon County Medical Society approved a Health Insurance Code in February 1961 which was presented to this conference, and

WHEREAS, solutions for hospital utilization which were presented at the Springfield conference were incomplete and in some respects contrary to the opinions set forth in the Macon County Health Insurance Code, and

WHEREAS, the Macon County Medical Society believes that the thoughts developed at such conferences should be subject to critical evaluation in order to establish definite policies at a state level with regards to health insurance, and

WHEREAS, the State of Illinois Medical Society has no Health Insurance Code,

NOW THEREFORE BE IT RESOLVED that the Illinois State Medical Society:

1. Continue to cooperate with the Illinois Hospital Association and other parties interested in health insurance.
2. Establish well defined policies with regard to the aims of organized medicine.
3. Detail a committee of physicians who are well versed in the official policy of the State Medical Society to promote the current concepts at general meetings.
4. Tape-record or otherwise monitor these meetings and the workshops so that any new thoughts developed can be carefully analyzed by the research unit of the State Society.
5. Establish communication with representative national organized units of labor (AFL-CIO), industry (N.A.M.), insurance (H.I.C.), and hospitals (A.H.A.) toward which implementation of these developed policies can be aimed.
6. Formulate a health insurance code.

E. A. Piszczek, M.D.
Establishment of a Section of Physical Medicine No. 33

WHEREAS, the specialty of physical medicine is recognized by the American Medical Association, and

WHEREAS, there is certification of physicians for this specialty by the American Board of Physical Medicine and Rehabilitation, and

WHEREAS, there is a component section of the American Medical Association known as the Section on Physical Medicine, and

WHEREAS, a number of state medical societies have established a Section on Physical Medicine, and

WHEREAS, the Chicago Society of Physical Medicine and Rehabilitation has been and continues to be active in this specialty, and

WHEREAS, problems of professional and scientific nature related to this specialty may arise in the deliberations of the Illinois State Medical Society requiring guidance by specialists in this field, and

WHEREAS, the duty of medical specialists is to teach the community of physicians as well as the community at large, and

WHEREAS, there is a growing number of specialists in Physical Medicine (physiatrists) who have settled in the State of Illinois,

NOW THEREFORE BE IT RESOLVED THAT (1) a Section on Physical Medicine of the Illinois State Medical Society be established and (2) the temporary officers of this section be selected from the Board of Governors of the Chicago Society of Physical Medicine and Rehabilitation.

Special Committee, Chicago Medical Society:
Walter Bornemeier, George Turner, L. F. Mommoser

Special Committee, Illinois State Medical Society:
E. A. Piszczek, A Brislen, E. McEnery
Establishment of a New Medical School No. 34

WHEREAS, the Foundation for Human Ecology of Park Ridge, Illinois, an arm of the Lutheran Church, is actively exploring and promoting the establishment of a new medical school to be located in the NW area of Cook County, and affiliated with Lutheran General Hospital, and

WHEREAS, this Foundation has, for the past two years, been in close and active contact with the Council on Medical Education and Hospitals of the American Medical Association and the Association of American Medical Colleges and has apparently accepted advice and has been guided by not only these organizations, but by the experience of funds and foundations with vast experience in the field of initiating organizations such as being contemplated, and

WHEREAS, a combined committee of the Illinois State Medical Society and the Chicago Medical Society, including representation from the area of the proposed institution has met with responsible representatives of the Foundation for Human Ecology and has been impressed by their understanding of the immensity of their undertaking and by their sincerity of purpose, be it therefore

RESOLVED that the House of Delegates of the Illinois State Medical Society approve in principle the activities designed to establish a medical school in this area under the sponsorship and guidance of the Lutheran Church.

Washington County Medical Society I.P.A.C. No. 35

WHEREAS, I. P. A. C. refuses to compensate Anesthesiologists for services rendered I. P. A. C. recipients undergoing surgery at St. Mary's Hospital in Centralia, Illinois,

NOW THEREFORE BE IT RESOLVED that the I. P. A. C. Committee of the Illinois State Medical Society recommend to the Illinois Public Aid Commission that this injustice to a group of our fellow physicians in the private practice of anesthesiology be corrected.

The Illinois State Medical Society Membership in the United States Chamber of Commerce No. 37

WHEREAS, the Chamber of Commerce of the United States has consistently demonstrated itself to be a strong and active advocate of free enterprise in all facets of business and professional endeavors in these United States; and

WHEREAS, as physicians we know that the best possible medical care is obtainable only under the free enterprise system as presently practiced in Illinois and other states of the nation; and

WHEREAS, there exists in America forces seeking to erode and eventually destroy the free enterprise system which has contributed immeasurably to the tremendous growth of the American economy with its benefits flowing to all our citizens, now therefore be it

RESOLVED, that the House of Delegates of the Illinois State Medical Society recommend to all physicians that they and their county societies become active in their local Chamber of Commerce and thus strengthen this force for free enterprise in Illinois, and be it further

RESOLVED, that the House of Delegates of the American Medical Association be urged to make a similar recommendation to all state medical societies that they become active in their national and state chambers of commerce to the end that the free enterprise system will be strengthened in America.

DuPage County Medical Society Medicine in Penal Institutions No. 38

WHEREAS, the very basic reason for the existence of this Society is for the maintenance and improvement of the health and medical welfare of all of our citizens, and

WHEREAS, we are bound by our personal and collective principles to practice preventative medicine to the best of our capabilities, and

WHEREAS, there is definite and woeful lack of an adequate medical survey of inmates in the vast majority of our penal institutions, and

WHEREAS, persons placed in many of our jails are all too often the victims of an infectious or contagious disease such as tuberculosis, therefore,

BE IT RESOLVED, that the DuPage County Medical Society propose to the Illinois State Medical Society that a proper committee be established from qualified members of this Society to work as a liaison body with representatives of such other State bodies which may be deemed appropriate in order to formulate and put into active practice at the earliest feasible moment a state-wide program for proper, early and adequate medical examination of all persons incarcerated in village, town, county and state penal institutions so that further spread of disease may be stopped.

DuPage County Medical Society Promotion of the General Practice of Medicine No. 39

WHEREAS, there is an outstanding concern that the GP, generalist, family physician or whatever he may be called, has been decreasing in numbers through the years, and

WHEREAS, 20 years ago 80% of graduating medical students were going into general practice, as compared to present day figures of 19.7% and

WHEREAS, this situation has come about because of shortsighted policies within the profession due to lack of suitable planning to provide the public with truly adequate medical care, and

WHEREAS, the public itself is rebelling at the role being forced upon it of becoming their own diagnosticians and deciding which of the specialties should be consulted,

THEREFORE, BE IT RESOLVED THAT, the Illinois State Medical Society endorse a program of exposing to and encouraging the medical student to enter into the general practice of medicine.

BE IT FURTHER RESOLVED THAT, the Illinois State Medical Society endorse a program of preceptorship of a medical student for a period of time during his senior year of medical school with an approved and qualified general practitioner of medicine.

BE IT FURTHER RESOLVED THAT, the Illinois State Medical Society carry this resolution to the Council on Medical Education to the American Medical Association for its endorsement and implementation on a national scale.

DuPage County Medical Society Foreign Medical Graduates No. 40

WHEREAS, a basic tenet of our Democracy is that each individual may be granted those privileges and prerogatives to which he is reasonably entitled by virtue of education, training, ability and capabilities, and

WHEREAS, we as physicians have a sincere desire to aid in every possible way our foreign trained colleagues, and

WHEREAS, at the present time there seems to exist some uncertainties at to the proper status of our foreign trained colleagues, therefore,

BE IT RESOLVED, that the DuPage County Medical Society does hereby propose to the Illinois State Medical Society that a special category, such as a Probationary Membership, be established in any given component County Society to permit trained physicians who have satisfactorily passed the State Board Medical Licensure Examination to be a part of organized medicine until the usual time has elapsed for said physician to become a naturalized citizen, and

BE IT FURTHER RESOLVED, that each component County Society clearly establish the individual physician's adequacy of medical training, his ability to communicate competently with his patients, and the proficiency of his medical capabilities, all of these to be determined to the satisfaction of the local society by interview, review of records and transcripts, oral and written examination and whatever other modality is deemed necessary in the best interest of all concerned, not the least of whom would be the potential patients of the physician being examined.

William O. Ackley, M.D. F.A.A. Medical Examination No. 41

WHEREAS, this House of Delegates at its regular 1960 meeting voted to approve limitation of medical examiners for student and private air pilots to physicians designated by the civil air Surgeon after assurance of appointment of any qualified physician who by his application has demonstrated interest in the program, and

WHEREAS examination for class II and class III airmen requires no special equipment or training, and

WHEREAS the Federal Aviation Agency has rejected for appointment as examiners some physicians,

THEREFORE BE IT RESOLVED that this House of Delegates request that the A.M.A. determine the reasons for rejections of these physicians, and further, whether the assurance given by F.A.A. Surgeon that qualified physicians who have demonstrated an interest in the program be appointed.

William O. Ackley, M.D.
Pension Fund No. 42

WHEREAS, the American Medical Association approved incorporation of physicians groups through which pension funds may be accumulated and

WHEREAS, most physicians are engaged in solo practice and have no tax sheltered advantage and

WHEREAS, the Department of Internal Revenue has recognized the right of a physician to leave with an insurance corporation, tax free, funds earned by him so as to accumulate an estate.

THEREFORE BE IT RESOLVED that this House of Delegates take steps to amend the law so that Blue Shield may act as custodial agent for these funds.

St. Clair County Medical Society
General Practice Training Programs No. 43

WHEREAS, many general practice residencies are unfilled, and many have inadequate progressive and integrated training programs; and

WHEREAS, the present two-year family practice pilot program of the American Medical Association could be improved so as to adequately prepare the young physician to do General Practice in his community; and

WHEREAS, each segment of organized medicine has and still determines the minute details and overall content of their respective training programs;

THEREFORE BE IT RESOLVED, that the Council on Medical Education and Hospitals be directed to formulate other two-year progressive training programs which are acceptable to the American Academy of General Practice, the only National Association representing General Practice.

W. H. Walton, M.D.
Appreciation to House of Delegates of A.M.A. and Board of Trustees of A.M.A.

WHEREAS, the International College of Surgeons Board of Regents at a meeting held in Chicago, May 14, 1961 passed a motion that the Board of Trustees of the A.M.A. be notified that the Board of Regents of the International College of Surgeons is grateful for the work that the A.M.A. is doing in attempting to prevent the passage of any legislation in Washington similar to the Forand type of bill, and

WHEREAS, the same feeling existed toward any legislation which might attempt to use the facilities of social security to accomplish the socialization of medicine in the United States, and

WHEREAS, the International College of Surgeons Board of Regents are grateful for the part played by the Illinois State Medical Society delegates to the A.M.A. on this behalf.

THEREFORE BE IT RESOLVED that the Delegates from the Illinois State Medical Society to the A.M.A. convey to the House of Delegates of the A.M.A. and the Board of Trustees of the A.M.A. the appreciation of the International College of Surgeons Board of Regents for their untiring efforts.

Eighth Council District
A.M.A. Clinical Session No. 45

WHEREAS, the Illinois State Medical Society has, from the operational standpoint, modernized itself in the past year and must continue to efficiently use its members dues and its members and employees time, and

WHEREAS: New needs arise for the efficient utilization of doctor's dues by both our state and our American Medical Association, and

WHEREAS, state and regional continuing education meetings (The Chicago Medical Society's Clinical Conference, The American College of Surgeons regional meetings, the American Academy of General Practice's local area conferences, and state medical society meetings) are doing an improved job of physician continuing education, and,

WHEREAS the physician attendance at the AMA clinical sessions over the past 10 years has not justified the efforts of doctors or of the AMA's paid staff, and

WHEREAS the record for the AMA Clinical Meeting from 1952 thru 1957 is as follows:

Year	Place	MD Attendance	Cost	Income	Loss
1952	Denver	2,614	$109,938	$45,430	$64,508
1953	St. Louis	2,730	118,029	62,866	55,163
1954	Miami	3,253	118,208	62,800	55,408
1955	Boston	3,779	122,207	69,450	52,757
1956	Seattle	2,813	124,118	59,475	64,643
1957	Philadelphia	2,637	125,524	85,415	40,109

WHEREAS, It has cost our Illinois State Medical Society over $60,000 in a five year period to send our delegates to the Clinical Sessions which bill averages approximately $1000 per delegate in attendance, and

WHEREAS a 1½ day session of the AMA House of Delegates, in Chicago, would care for the policy making decisions needed for American doctors, at less than half the cost to the *physicians of each state* of sending their delegates to a five day clinical session.

THEREFORE BE IT RESOLVED: That this House of Delegates instruct its delegates to the AMA to introduce and work for the passage of a resolution that will save our members dues for better purposes, improve the efficiency of the AMA House of Delegates operation, render our public and our physician members better service, and recommend to the AMA Board of Trustees that the annual Clinical Session be discontinued now.

E. A. Piszczek, Chairman of the Council
LOOK Magazine Article No. 46

WHEREAS, it is imperative that the American public should be fully informed on all aspects of the major issues of our day of which medical care to the aged is one, and

WHEREAS, Look magazine has undertaken to perform this service on this issue by publishing the article "A Family Doctor's Fight Against Socialized Medicine" in its issue of May 23, 1961;

NOW THEREFORE BE IT RESOLVED by the House of Delegates of the Illinois State Medical Society that this body go on record as commending Look magazine for publishing this artcle in the issue of May 23, 1961, and

BE IT FURTHER RESOLVED that Dr. Joseph Mallory of Mattoon, be commended for his contribution to public enlightenment, and

BE IT FURTHER RESOLVED that copies of this resolution be forwarded to the editor of Look magazine and to Dr. Joseph Mallory.

(Dr. Bornemeier, Chairman of the Committee on Constitution and Bylaws, presented a supplementary report of proposed changes, all of which appear later in this record in connection with the reference committee report.)

SECOND SESSION
Tuesday, May 16, 1961

The second meeting of the House of Delegates of the Illinois State Medical Society Annual Meeting was convened at the Hotel Sherman, Chicago, Illinois at seven-forty-five o'clock p.m., Dr. H. Close Hesseltine, presiding.

PRESIDENT HESSELTINE: We now come to the matter of the selection of the meeting place for the 1964 Annual Meeting.

SECRETARY REISCH: According to Chapter II, Section 2 of the Constitution and By-laws, it is the responsibility

of the House of Delegates to select the city in which the meeting of the Society shall be held each year.

I move that this House of Delegates go on record for holding the 1964 Annual Meeting in Chicago. (Adopted)

PRESIDENT HESSELTINE: It is the pleasure of your President, at this time, to take a brief moment to pay a little compliment to one of our faithful employees. This individual has completed twenty-five years of service for the Illinois State Medical Society, as of January, 1961.

Therefore, at this time, I would like to call on Dr. Hamilton to make a presentation.

DR. HAMILTON: I consider it a great privilege to be allowed to make this presentation at this time.

I have been a member of this House and have been waited upon by the recipient of this award since I started working in this organization and I might further add that in over twenty-five years, I have never worked with anyone who was more accommodating and who has given more unselfishly of themselves and their ability to an organization than the recipient has to us.

Now then, if there is any doubt here in anyone's mind as to who I am talking about, I am talking about Mrs. Zimmer.

This large box here is not filled with gold, as, of course, it should be. However, it is just filled with silver and, further, I deem it a great privilege to be allowed to give this to you, Mrs. Zimmer, at this time.

MRS. ZIMMER: I want to thank all of you but I especially want the privilege of thanking Dr. Hamilton. I am so glad that he was the one to have given it to me because over the twenty-five years of association we have had, I could have worked for no finer individual. Thank you one and all.

DR. REISCH: We have a telegram from Louis M. Bauer of the World Medical Association, addressed to George B. Callahan, for the Illinois State Medical Society.

"Please present the greetings and best wishes of the World Medical Association and its United States Committee to the Illinois State Medical Society for a most successful meeting. The World Medical Association, which is the only representative organization for practicing doctors on the international level is constantly endeavoring to protect the standards of medical care, medical education and freedom in the practice of medicine."

Dr. W. H. Whiting moved acceptance of Resolution 46 without reference. Dr. Percy Hopkins offered an amendment to the resolution commending Dr. Mallory of Mattoon for providing the material in the Look magazine article.

Dr. Leo Sweeney offered a second amendment providing that the resolution be sent to the editors of Look and to the publisher of the Illinois Medical Journal and that a copy be sent to Dr. Mallory in letter form. (All amendments and the motion carried)

Reference Committee on Reports-of Officers, Councilors, AMA Delegates and the Illinois Medical Journal.

Dr. Paul A. Dailey, Chairman
Reports of Officers

The committee is impressed by the major contribution made by Dr. H. Close Hesseltine in behalf of the physicians in private practice, and wishes that more individual doctors in teaching institutions would make similar contributions to organized medicine. It is regretted that a large number of physicians who are teaching the doctors of tomorrow and who have so much to offer this Society are not members of the Illinois State Medical Society.

The committee recommends the implementation of suggestions No. 2 and 3 in the President's supplementary report. The committee wishes to emphasize the importance of the President's recommendation No. 4 and No. 5 and state that they concur in the remaining suggestions of the President's report. (Adopted)

The brief report of the President-Elect does not reflect the time and work contributed by Doctor Hamilton during the past year. The committee is pleased that the Society will continue to be in capable hands during this phase of the organization's development. (Adopted)

The efforts of the Second Vice-President, Dr. Clinton Swickard, contributed greatly to the work of the Society. His recommendations were noted. (Adopted)

The committee concurs in the Secretary-Treasurer's recommendations for a more efficient liaison between state and county secretaries. His recommendation concerning a secretary-treasurer's conference is noted and it is suggested that it be referred to Mr. Richards for his consideration with the alternate possibility of implementing this at the district level through field secretaries.

His additional recommendations are in effect.

It is noted that there are 400 fewer members in the society than in 1960. This points up the necessity of the proposed membership drive. (Adopted)

In addition to a careful review of the report of the Executive Administrator, the committee has inspected the new offices of the Society and has explored the administrative setup in detail. It is the committee's opinion that great progress has been made in implementing the directives of the 1960 House of Delegates. The committee is unanimous in its commendation of the enlarged and efficient administrative staff. The committee was pleased to learn from Mr. Richards that the administrative work can be handled by the present staff within the proposed budget.

A great amount of time was spent in hearings on the budget. Mr. Pelman of the auditing firm, Dr. Montgomery, chairman of the Finance Committee and the society's President, Dr. H. Close Hesseltine, Mr. Richards, Executive Administrator, various councilors, delegates and interested members were heard.

The discussion pointed out that the interest rate on the Society's reserve fund can be increased within the bounds of conservatism and safety.

It was brought out that the Finance Committee has no written statement of policy, and it was suggested that they formulate one for the guidance of Mr. Richards and Mr. King.

The committee noted Mr. Richards' suggestion in the supplementary report concerning the 25 Medical Service Areas, and recommends that the President appoint a Study Committee to bring a report to the Council and to the House of Delegates concerning this matter.

The committee is impressed by Mr. Richards' executive ability and cooperation and by the excellence of the staff which he has assembled.

The organization and printing of the Handbook and other material for delegates was an outstanding job. (Adopted)

DR. REISCH: Mr. Chairman, I would like to make a correction if I may. I would like to explain and make a correction referred to in this report concerning the membership in the Society, as noted in the report of the Secretary-Treasurer. The report states that there are 400 fewer members of the Society than in 1960. That, according to the figures as listed, was correct. However, this was a report given only for an eight-month period, due to the change in fiscal policy of the administration. Consequently, our membership is not 400 members less. I do not have the figures here but it is approximately the same as last year.

DR. DAILEY: The Councilors are to be complimented for their achievements both in their respective districts and as a group. It is recommended that their reports be accepted as printed in the Handbook. (Adopted)

With regard to the report of the Councilor At Large, the committee advises:

The last paragraph of Doctor O'Neill's report epitomizes his spirit and contribution to the Society. "Again I want you to know I am deeply appreciative of the

honors bestowed upon me. I do not intend to sit back and watch things from the side line, and I hope my voice will still be heard as a member of the House of Delegates for years to come. I shall do everything I can to help." (Adopted)

DR. DAILEY: Regarding the report of the Delegates to the AMA, the committee was honored by the appearance of Dr. Percy Hopkins, long time delegate from the Illinois State Medical Society to the American Medical Association, and currently a member of the Board of Trustees of the AMA. Dr. Hopkins discussed at length the work and activities of the Illinois delegation and the increase in committee appointments for our delegates. (Adopted)

The report and the supplementary report of the Chairman of the Council, Dr. E. A. Piszczek, is indicative of the magnitude of the work done by him in the Council. We recommend the acceptance of his report with appreciation. (Adopted)

The committee wishes to commend the Editor, the Journal Committee, and the Editorial Board for their reports and the excellence of the Journal. (Adopted)

Pertaining to Resolution 1961-4, 1961-26, 1961-31, the committee reports as follows:

The subject matter of these three resolutions was Social Security for physicians.

The committee recommends the adoption of resolution 1961-26 and 1961-31 and the rejection of resolution 1961-4.

The committee also recommends that the pages of the Illinois Medical Journal be open to comment by members for and against Social Security for physicians. We further recommend that the President of the Society appoint or designate a committee to summarize the arguments for and against physician participation in the Social Security System, and to supervise the carrying out of the survey. Pertinent factual data and the summary of arguments pro and con should accompany each ballot. Results of the survey should be available for transmission to the House of Delegates of the AMA at its Clinical Meeting in Denver beginning November 27, 1961. We further recommend that the results of the survey be published in the Illinois Medical Journal.

Further, on the subject of Social Security, the Reference Committee recommends to the committee to be appointed or designated to conduct the survey that the form of the survey ballot be:

1. Are you now covered by Social Security? (Yes or no.)
2. If not, are you in favor of Social Security for yourself? (Yes-No)

I so move.

DR. HOPKINS: Certainly, one should not oppose a polling of the membership with regard to a question of policy. However, I think that to set down as a mandate a questionnaire, with the idea that it shall constitute a survey to be composed of only two questions such as I interpret this recommendation of the committee would, it seems to me, be entirely inadequate.

There has been some confusion in connection with similar surveys which have been entirely incomplete. The doctor was not conversant with it and, further, there is much information available from AMA headquarters on both sides of the fence.

Therefore, it seems to me that it would be wise to allow the committee to determine its own questionnaire.

One glaring defect that I would find in the second question is the fact, gentlemen, that Social Security is compulsory—it is not just Social Security.

I would amend this motion by deleting these two questions to be included in the questionnaire and offer the committee an opportunity to establish its own questionnaire.

DR. SCHIPPER: One of these resolutions originated in my county, Knox County two years ago and I was unable to attend the committee meetings at that time because I was ill and, therefore, it was tabled.

My county society gave me to understand they wanted me to follow this through. We feel and we hope that this state medical society is a democratic organization. All we want to learn from any doctor is whether he is in favor of Social Security for himself. Of course, most of our doctors have some gray matter in their head and, consequently, they can determine for themselves whether they want Social Security or not. This is all we want the members of the State Society to do.

We are not forcing Social Security on any one. We want to know where the members stand.

I would also like to inform you I checked with the Social Security Secretary and, off-hand, they give a figure of almost fifty per cent of the doctors as being covered. Now then, the other fifty per cent are practitioners such as myself, who are singletons, soloists and, therefore, we hope that each and every individual doctor will say whether he or she wants Social Security.

That is all there is to it. It is a democratic ballot and we hope that the organization is democratic enough to ask its members whether they want it or not.

DR. HAMILTON: I certainly have no objection at any time to polling the membership and I think we should always do those things. However, I would like to bring to your attention, based on previous experience with polls, the fact that I question the advisability, first, of telling when the report should be ready. I think that the publishing of such a report should be predicated upon the number and amount of answers. With 11,000 members, a report from two or three thousand, I do not think, would be fair. Therefore, for that reason, I would hope that you would give this to a committee which I hoped would be appointed so that there would be no criticism of it. I would hope you would give to that committee the privilege of making the report, when, as and if an adequate number have answered the questionnaire and that they will not be limited by time as to when to report.

I have conducted two or three of these questionnaires and I can tell you it becomes pretty discouraging when you send out ten thousand of them and get back three hundred.

I don't think that under those conditions we should ever send out a report.

DR. SAXON: I am grateful for the remarks made by Dr. Hopkins. I wish those of us as ordinary delegates would have a Dr. Hopkins available to cover us in the absence of these committee meetings. Obviously, most of us cannot attend some of these meetings. Sometimes the committee meetings that we choose to attend in order to voice our opinions cannot be made due to business we have elsewhere.

However, regarding the question as to whether or not a doctor is covered by Social Security, I should like to point out to you gentlemen, as Dr. Hopkins mentioned, that Social Security is a compulsory item. It is not subject to voluntary desire but is a compulsory item and, thereby, a freedom eroding process.

On this particular subject matter, when you are dealing with issues that are of vital nature, as is such an item concerning the freedom of the individual, I do not feel, from previous experience (and also confirming the remark made by Dr. Hamilton) that it is a very nice thing.

I think, also that there should be close to a hundred per cent contribution of the total membership of our Society in reaching the determination of such a poll. Of course, this can only be done by the local county medical societies taking upon themselves individually the aspect of polling their own membership and coordinating it down to the base line. Therefore, as a function of the Illinois State Medical Society per se, this is a very difficult and totally unsatisfactory method.

DR. ACKLEY: The New York Society of Social Security polls or whatever it is, conducted one year in

Illinois which was not official. It seems as though each time some group gets together on Social Security that they run their poll up. I think that the last one I saw about sixty-seven for and thirty against. However, I don't think that is true.

Talking about being honest about it, I think some cases are being falsified. I don't think that the poll, insofar as it goes, unless it is conducted by the Society, would say too much.

I think that if we give these Councilmen half a chance to take care of this resolution as put out by the Council and Society, that this will take care of the Social Security by itself and we would not give up much more freedom than you now would have under Social Security.

DR. BORNEMEIER: I rise to support the amendment for this reason. I think there are two questions involved here.

Dr. Hopkins wants these items 1 and 2 eliminated. The first question states: "Are you now covered by Social Security?" and then it provides for a "yes" or "no" answer.

The second question states, "If not, are you in favor of Social Security for yourself?" There again, it provides for a "yes" and "no" answer.

Well, if you answer "yes" to the first one, then you do not get a chance to answer the second one. Therefore, the poll that we would have, if fifty per cent of the people are already covered, this means that only half of the doctors will get a chance to vote and, therefore, somebody can tear that to pieces because it is not representative of the people of Illinois.

Therefore, I support the amendment.

DR. L. F. ROCKEY: Resolution No. 1961-4 came out of our county. What Dr. Saxon said is right. I prefer that the county should individually be polled.

When our county was polled we found, much to our surprise, that eighty-five per cent of all of the men in the county wanted the doctors included under Social Security. Let's get down to the grass roots and leave the men have their say. Let each county poll itself and then decide what the vote is.

DR. TICHY: Before the counties are polled relative to Social Security, I think it would be a very good idea for everybody in each county society to try to understand Social Security. Very few people in the country do. The government has fooled most of them relative to Social Security to date and therefore, I shoull like to have the doctors take a darn good look at it before they fall for it.

DR. O. W. REST: I rise to support the amendment. It seems to me that not only should this questionnaire be very carefully thought out but, if it is administered or taken on a county basis, that the same questionnaire should be used everywhere and the results forwarded to one central committee who has prepared the questionnaire.

DR. BRISLEN: I propose the substitute motion, to substitute for that portion of the report following the sentence. "the committee recommends the adoption of Resolution 1961-26 and 1961-31 and the rejection of Resolution 1961-4", the following substitution: "We recommend that the Council of the Illinois State Medical Society appoint a committee to conduct a secret poll by mail of the membership of the Illinois State Medical Society on the question of their Participation in Social Security; that this poll be conducted with the greatest haste practicable; that the results be reported to the Illinois State Medical Society in the manner best applicable and that the delegates to the American Medical Association be requested to forward the results of this poll to the House of Delegates of the American Medical Association." (Adopted)

DR. DAILEY: With reference to Resolution 1961-7 the committee makes the following report:

The committee is in sympathy with holding the line on dues. The officers of the Illinois State Medical Society have stated that the Society's dues will not be increased in the foreseeable future. However, an increase by the AMA for dues of $10.00 in 1962 and again $10.00 in 1963 is already agreed.

The budget was discussed in detail and the delegate from the Jackson County Medical Society was present at this time. All delegates have been furnished with a detailed financial statement of the Illinois State Medical Society. The financial statement of the AMA appears annually in the AMA Journal.

The committee recommends that the third "Whereas" section of resolution 1961-7 be deleted and that the resolution as thus amended be adopted. (Adopted)

With reference to Resolution 1961-12, your committee reports as follows:

The Director of Public Relations and the Council Committee on Public Relations are to be urged to increase their efforts to educate doctors and the public to the dangers of Socialism and socialized medicine.

The Reference Committee recommends that this resolution not be adopted.

DR. SAXON: This particular resolution was for the purpose of delineating, outlining and distinguishing the part that should be played as to how government should influence the health of people. We feel that we have an inherent duty and obligation insofar as the protection of the health and mental welfare of the people in this country are concerned and that anything that is a cause for disease is necessarily secondary to the inference that the influences of government should be considered.

I would move that the Kendall County Resolution, for the purpose of delineating and isolating a committee for this particular purpose, be adopted.

DR. WHITING: My only comment is with reference to political activity. The Illinois State Medical Society, as an organization, cannot indulge in political activity. Individual members, however, are so privileged.

We have a Committee on Medical Service who are responsible for the presentation of our opinions in the form of legislation, but it is not our privilege, as a corporation, to indulge in political activity.

(The question was called for, the motion was voted upon and was declared to be carried.)

DR. DAILEY: We next come to a consideration of Resolution 1961-14.

The opinion of the Reference Committee is that the Illinois State Medical Society as an organization should not engage in political activities. It should be noted that the Illinois Medical Political Action Committee (IMPAC) has been established for these purposes. The committee recommends that this resolution not be adopted. (Motion adopted)

I now move the adoption of this report as a whole, as amended. (Adopted)

I would like to make an additional comment.

Members in good standing as of March 31, 1961 totaled 3,316; new members added during April were 45; reinstatements were 6, bringing us up to a total of 3,367. However, in the same month, 18 doctors died, 15 moved away, 4 resigned and 4 were dropped for non-payment, totaling 41. There was a net gain of 4 members during the month of April.

Reference Committee on Constitutional Committees
Dr. Kenneth Scatliff, chairman

COMMITTEE ON ARCHIVES: The Committee is doing a continuing job in excellent fashion. You will note that they make three recommendations which we urge you to support. They are printed in your Handbook and represent the basic requirements for the success of this committee. Second, a proper indexing and safeguarding of our records will testify to future generations that ours is a virile society. (Adopted)

COMMITTEE ON BENEVOLENCE: This committee carries on splendidly despite the handicap of insufficient funds for current expenditures. Two dollars of your yearly dues is allocated to this fund. Monthly payments to

beneficiaries of the fund currently totals $3,000.00. The excess expenditure over receipts, on an annual basis, is $6,411.04 The Woman's Auxiliary has been most generous in their contributions. Just recently a letter and checks were received—too late for inclusion in the Benevolence Committee report—from Mrs. Newton DuPuy, Treasurer of the Auxiliary, enclosing checks for $1,008.30 and $10.-00. The $10.00 donation was in memory of Dr. and Mrs. Charles W. Stigman, recently deceased. These memorials cover the period from April 3, 1961 to this date. I believe this House can join with the Benevolence Committee in extending a warm "Thank You" to the Auxiliary. (Adopted)

THE GRIEVANCE COMMITTEE: The report indicates that they exercised a very satisfactory working contact with county and district Grievance Committees. We join the committee in their thought that the best method of handling grievances is to stop them before they occur. They urge physicians to discuss more freely the subjects of fees with their patients and in addition that each county society make known to the public the existence of such local committees in its area. (Adopted)

COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS: The committee has followed through extremely well with the work that was assigned to them by the last House of Delegates.

Their recommendation regarding licensure before citizenship requirements are completed is in process of becoming law in House Law Number 140. The Committee on Medical Education and Hospitals has a strong feeling that either a rotating or a straight internship should satisfy the Medical Practice Act requirements. Your Reference Committee has been officially informed by the Medical Examining Committee of the Illinois Department of Registration and Education that a revised rule permitting straight internships in appropriate circumstances was adopted on May 16, 1961. The text of the rule is as follows: RULE III

2. An approved internship shall consist of a twelve months' rotating service in medicine, surgery, obstetrics and pediatrics, with an election in medical specialties; provided, however, that any applicant who shall have completed twelve months' of clinical training in a hospital, as required by Section 5, 1(b) of the Medical Practice Act, and who has been accepted for further training in a specialty or general practice residency program by a hospital or institution approved by the Department for that purpose, shall be deemed to have complied with the requirements of this rule and of the Medical Practice Act in this regard. (Adopted)

THE COMMITTEE ON MEDICAL SERVICE: The work of this committee is very comprehensive and with all of the legal complications involved has been extremely well handled. Your Reference Committee feels that they have kept a close watch on those matters vital to public and professional welfare. Several facets of their work will be presented in the resolutions considered at this session of the House. Rightfully, they state that their most important task at the present time is the acceptance and implementation of the Kerr-Mills Law with the recommendations of the Illinois Medical Society included in the same, as now pending before the legislature as Senate Bill 197. While the Illinois Public Aid Commission apparently agrees in the substantial value of the Kerr-Mills Law they have erected certain road-blocks incorporated in House Bill 1267 which they have caused to be introduced.

On the five points of difference the Committee on Medical Service recommends that we amend our position on SB #197 to present the following:

1. Asset provision of $2000 liquid assets permitted, plus $500 for each dependent (same as SB #197)

2. Income test of $1800 plus $600 for each dependent (same as IPAC proposed provision).

3. Catastrophic provision of assets $2000-$8000 for single persons or $2500-$10,000 for applicant with spouse or dependents, subject to contributory provision of 10 per cent (same as SB #197).

4. Medical Care Program with control of the size and scope of care to be under the IPAC (IPAC provision).

5. Provision whereby the IPAC would be authorized to pay usual and customary fees prevailing in the local community. (same as SB 197)

It will be noted that our committee has accepted the IPAC proposals in several areas but at the same time have desired to maintain those provisions deemed completely necessary for good medical care. The committee appears to be entirely conscientious in this matter and your Reference Committee believes they should be supported by this House. (Adopted)

MEDICAL TESTIMONY COMMITTEE: We especially commend this committee for having established such a splendid record in the past that they have been able to keep the duties of this year completely minimal. (Adopted)

MEDICAL-LEGAL COMMITTEE: Deserves our thanks for maintaining an excellent liaison with the legal profession and its thorough survey of medical consent forms. (Adopted)

COMMITTEE ON PREPAYMENT PLANS AND ORGANIZATIONS: This committee has done an excellent piece of work in meeting with representatives of the insurance industry and having them agree to the use of a uniform claim form. They make three recommendations for our guidance which you will find in their report and we urge your cooperation in this matter. (Adopted)

COMMITTEE ON PUBLIC RELATIONS: A survey of this material suggests a remarkable job of organization and accomplishment in the ten months this group has been functioning. The Physician's Placement Service is now being directed by this Committee and with it they are building good will and good public relations in various communities throughout the state. By skillful use of their staff personnel, various divisions have been established which carry on activities ranging from the publication of a monthly newsletter — The Pulse —, to regional meetings with county societies and branches. The five subcommittees they have authorized and made operative with their committee members as chairmen of each subcommittee, will embrace the entire field of good public relation activity. To insure the continuing participation of these members in the over-all public relations program, it is respectfully suggested that individual reports be made by the chairmen of the subcommittees to the general chairman. It is difficult to single out one activity more worthwhile than another but we commend their work in bringing to the public proper information regarding the Kerr-Mills Law, the promotion of good community relations, and the development of indoctrination programs to the end that our own members will be better members — more understanding members of the profession.

The Reference Committee hearing brought out the fact that while the Public Relations Committee and its staff is doing a good job there is a regrettable amount of apathy among our own members. (Adopted)

Your Reference Committee has studied and held hearings on Resolutions 1, 3, 5, 6, 8, 13, 15, 18, 20, 21, 27, 29, 34, 39, 40 and 43. We have considered these resolutions in executive session and would comment as follows:

Resolution No. 1 introduced by the Madison County Medical Society reads as follows:

"WHEREAS, the Joint Commission on Accreditation of Hospitals is not controlled by the House of Delegates of the AMA, and

"WHEREAS, The Joint Commission on Accreditation is a policy making body whose decisions vitally effect the medical care of patients by the medical staff of hospitals, now

"THEREFORE BE IT RESOLVED: That the House of Delegates of the AMA hereby terminate its association with the Joint Commission on Accreditation and hopes that the American College of Physicians and the American College of Surgeons will terminate their association also, and

"BE IT FURTHER RESOLVED: That the Council on Medical Education and Hospitals is directed to organize and direct the activities of a committee whose sole purpose shall be to inspect and advise the medical staff of any interested hospital as to its relations with the public and lay hospital boards."

Our investigation shows that the Joint Commission on Accreditation of Hospitals is not a policy-making body. They assert that they establish standards and follow policies enunciated by the American Medical Association. Their Board of Trustees is made up of 20 individuals elected for 3 years and selected by the Boards of the participating agencies in this proportion, namely, 7 from the AMA, 3 from the College of Physicians, 3 from the American College of Surgeons and 7 from the American Hospital Association. Of this 20, 17 are M.D.'s and 3 are non-M.D.'s. With this information, your committee submits the following substitution as a concluding resolve for the original resolution and the last WHEREAS.

"WHEREAS, the Joint Committee on Accreditation of Hospitals is a body whose decisions vitally affect the medical care of patients by the medical staffs of hospitals and frequently causes dissension between the staff and the management, now

"BE IT RESOLVED: That the said Joint Accreditation Commission exercise greater care in the selection of its hospital examining personnel, and that a consultation with the staff officers be held before adverse decisions are rendered, and

"BE IT FURTHER RESOLVED: That this resolution be forwarded to the AMA House of Delegates with the request that the AMA representatives on the Joint Accreditation Committee be apprised of this situation to the end that a better degree of understanding may be developed."

DR. MANTZ: I arise to oppose the action of the Reference Committee with reference to our resolution.

My county society had a very unpleasant experience with our recent so-called inspection. Everybody in our county had become extremely angry with the dictatorial, commanding general attitude of the examiner. To this extent, the Reference Committee is correct. However, this question is much deeper than this and we in the county began to explore it and we felt that we no longer wanted any part of a Joint Commission. This was passed unanimously by the Madison County Medical Society and I can say this in all truthfulness, that I have never heard a doctor in our county who has a good word to say for the Joint Commission.

This also prevailed at the Reference Committee meeting. There was not a man in the room who had one good thing to say for the Joint Commission. There was absolutely not one word of testimony in favor of it. On the contrary, many of the doctors there spoke out vigorously against the Joint Commission.

Now then, I would like to review for you some of the facets of this problem.

All of you who are familiar with the Joint Commission activities know the methods that these inspectors use.

They come into a hospital with a set of rules in their hand and attempt to tell the hospital staff how they should run their hospital.

He came into one of our hospitals which they put on probation with some of the silliest recommendations that I think I have ever seen. For instance, for years, in this hospital, we have pasted our pathology reports on a sheet, pasted them in so they could not be lifted up. The oldest ones always were on the bottom. The inspector told us we could not do that any longer, that we would have to turn the chart sidewise and read them on there. It is these kinds of ridiculous things, I suppose, that placed our hospital on probation.

I would like to quote from the report: "The bylaws, rules and regulations of the medical staff should be reviewed as to content to conform with the principles of the Commission."

Now, members of the House of Delegates, if I were running a hospital and had a hospital staff, I certainly should have the privilege of having the constitution and bylaws of our choice, not that of the Joint Commission.

I could go on and give you other illustrations.

Now then, with regard to our resolution. We do not, in any sense, feel that hospitals should not be inspected thoroughly but we disagree with the method of doing it.

Now then, let me call this to your attention. The Council on Medical Education and Hospitals already inspects hospitals in this country to a certain and very great extent. First of all, they must do this in approving a medical school. All medical school hospitals are inspected and they are inspected for internship and for residency.

However, the grass roots membership of the American Medical Association, I am certain, is fed up with the Joint Commission. This is a fact and any of the delegates who will examine their own conscience will know this is true. We are here to represent these people and, therefore, we must act in their interest and according to their wishes.

The Reference Committee wants to spank these people and call attention to some of their deficiencies. We can correct this wrong by getting better examiners or asking for consultations and that they do something. The Joint Commission knows this very well. I think they have to be told about this repeatedly. Further, this has been done in the past and they have never done anything about it.

MEMBER: I have a proposed substitute resolution that I would like to introduce.

I would like to move that the report of this Reference Committee be amended to read as follows: "All of page 7 after the first paragraph to be deleted and the following substituted in place thereof: 'Your Reference Committee recommends that this resolution be adopted and that the delegates to the AMA from the Illinois State Medical Society submit this resolution to the House of Delegates of the AMA at their June meeting, 1961 and do everything necessary to have it adopted by that body.' "

DR. R. R. MUSTELL: I believe that all problems involving doctors should be completely controlled by the doctors' organization. In other words, the resolution brought out by the Madison County Medical Society means just that. It means that the control and the operations of the doctors are in their own hands.

I would just like to take a moment and talk about the staff that makes up the accreditation board. I am always mindful of the good work that they have done in the past but when the AMA only has seven representatives on that Board and the AMA has from 25,000 to 50,000 general practitioners, then it doesn't look like the general practitioners are getting adequate support.

DR. SCATLIFF: I would like to point out, with reference to control of this action of the Joint Commission of Accreditation, that the resolution that Dr. Mantz presents from the Madison County Society suggests that it be managed by the Medical Education and Hospital Commission. We have assumed that he means the Medical Education and Hospital Commission of the AMA. That Commission is only controlled by the House of Delegates of the AMA and we can only appeal to them through the AMA and, therefore, we would have no more control over them than we do now.

The second thing that I would like to point out is that Blue Cross pays the hospitals and Blue Shield pays the doctors. There are many, many hospitals which Blue Cross pays that are not approved by the Joint Accreditation. A hospital of fewer than twenty-five beds is not eligible for inspection by the Joint Commission of Accreditation. Those bills are paid by Blue Cross.

There are also other instances of which I have personal knowledge wherein Blue Cross has continued to pay bills from certain hospitals. The County Hospital, at one time, was not approved by the Joint Commission on Accreditation but Blue Cross continued to pay bills arising there.

DR. E. K. DuVIVIER: The resolution presented by Madison County is not intended as a criticism of the Joint Accreditation. The resolution presented by the Madison County Society is only intended to put the

burden where it belongs, in the AMA and among doctors.

(The motion was then voted upon and it was the ruling of the chair that the motion was carried.)

RESOLUTION No. 3 as introduced by the Chicago Medical Society establishes as a matter of record, that the Illinois State Medical Society is a non-partisan association. We recommend that the last paragraph, "BE IT FURTHER RESOLVED" be deleted and both Resolves of this resolution read as follows:

"BE IT FURTHER RESOLVED: That it is the responsibility of the executive administrator of the Illinois State Medical Society to determine that the publications and public statements by his staff be strictly non-partisan unless specifically authorized as aforementioned." (Adopted)

RESOLUTION: No. 5, 20, 27. all these resolutions deal with the subject of medical laboratories as run by persons without medical licensure. Resolution No. 5, introduced by Winnebago County Medical Society, includes a provision that it be forwarded to the House of Delegates of the AMA for their consideration. Your Reference Committee recommends no action on Resolutions No. 5 and 20, but recommends the adoption of Resolution No. 27 and an added Resolve carrying out the intent of Resolution No. 5 Resolution No. 27, submitted by the Illinois Society of Pathologists will therefore read in its final conclusion:

RESOLVED: That the Illinois State Medical Society hereby declares that, the proper conduct of laboratory analyses is a medical professional responsibility and all specimens for such analysis should be referred to laboratories supervised by fully qualified and licensed physicians, and

BE IT FURTHER RESOLVED: That copies of this resolution shall be distributed to the membership of the Illinois State Medical Society, and

BE IT FURTHER RESOLVED: That this resolution be presented to the House of Delegates of the AMA by delegates from the Illinois State Medical Society. (Adopted)

RESOLUTION No. 6 Sangamon County Medical Society. It deals with "third parties" and fees for services and received a great deal of suport from various specialty societies across the state. It appears that these societies and the proponents of the resolution have knowledge not possessed by the rest of us since the last "WHEREAS" reads "WHEREAS, the Council of the Illinois State Medical Society will, in the future, have to contract with third party groups.', and then goes on to read: "NOW THEREFORE BE IT RESOLVED that in the future, the Council of the Illinois State Medical Society consult with a committee composed of representatives of each group or specialty, such as the American Academy of General Practice, American Society of Internal Medicine, American College of Surgeons, American College of Radiology, etc., before making any final contract with any third party organization involving fees.

Your Reference Committee recommends the adoption of the resolution amended as follows starting with the last "WHEREAS:

"WHEREAS: The Council of the Illinois State Medical Society may in the future have to contract with third party groups, and the Resolve to read: "NOW THEREFORE BE IT RESOLVED: That if or when it should become necessary to negotiate with third parties relative to conditions of the practice of medicine, that the Council of the Illinois State Medical Society appoint an ad hoc committee from its membership and from the membership at large, which members should be conversant with the practice of all specialties within the state, for the purpose of study and exploration of the problem before a contractual decision is reached." (Adopted)

RESOLUTIONS: No. 8, 43, 17 and 39. The first two deal with the shortage of general practitioners and with the inadequacy of residency training programs. The latter two deplore the tendency of the medical schools to turn out specialists and proposes to correct this tendency by instituting a program of preceptorship during the medical students' last year. Your committee is deeply sympathetic with these obvious needs but we are troubled about the proposed solutions. The resolved portion of No. 8 reads, "THEREFORE BE IT RESOLVED: That the Council on Medical Education and Hospitals be requested to formulate other pilot two-year progressive training programs in consultation with the American Academy of General Practice", and that of No. 43 reads, "THEREFORE BE IT RESOLVED: That the Council on Medical Education and Hospitals be directed to formulate other two-year progressive training programs which are acceptable to the American Academy of General Practice, the only National Association representing General Practice. The writers of these resolutions do not so state but when they refer to the Council on Medical Education and Hospitals they have advised us they mean the Council of the AMA so named. It must be stated that we have no power to direct the actions of this Council. Our only access to them is through the House of Delegates of the AMA, just as any member of the AMA can present a resolution to them. The subject matter herein considered is so important that we hesitate to recommend disapproval. We, therefore, recommend no action on these two resolutions but recommend the following substitution which is a distillation of both.

"WHEREAS, the need for more and better training in a general practice residency program seems apparent, and

"WHEREAS, many general practice residencies are unfilled and many have inadequate progressive and integrated training programs, and

WHEREAS: each segment of organized medicine has control of and determines the details and over-all content of their respective training programs,

BE IT RESOLVED: That our delegates to the AMA be instructed to present this matter to the House of Delegates of the AMA with a request for cooperation with the American Academy of General Practice looking to the improvement of this situation." (Adopted)

RESOLUTION No. 17-39—The tenor of its subject as relating to general practice has been noted and since this is covered in the others we recommend no action on this resolution at this time. Resolution No. 39 is introduced from the DuPage County Medical Society.

In reference to the second resolved, it will be noted that the matter of a program of prceptorships for senior medical students could only be operative through the schools. We, therefore, recommend that this resolution be referred to the Council for study and discussion with the proper agencies.

DR. GIBBS (Madison County): I think that what has been done here in the first resolution relative to Postgraduate Education is very good. However, it doesn't solve our problem as far as Dr. Saxon mentioned.

I think, first of all, that we have to get to the root of the problem by considering the problem of medical education at the graduate level. Certainly the men in general practice, not those in general practice only but in the practice of medicine generally, realize that the community has certain health needs and that many of the goals of medical schools and many of the training objectives no longer fit into the actual community needs and, therefore, I certainly think that the Council should get together with these agencies and discuss training objectives, discuss present-day goals of medical schools.

I would hate to see this thing get lost in the shuffle because I feel it is extremely important. Therefore, I suggest that this report be adopted with the following recommendation—that the Council report back to this committee next year to let us know what progress has been made in this area. I would like to offer that as an amendment.

(The amendment was then voted upon and was declared to be carried.)

DR. SCATLIFF: Your Reference Committee is in entire agreement with the Kendall County Medical Society in their desire to preserve individual freedom, and we are in complete accord with them in the first "WHEREAS," namely that the Illinois State Medical Society has an adequate and capable legal staff. Nevertheless, we must point out that to purspe, even unmolested, a lawsuit might well represent a considerable expense to which we as a committee cannot commit the Society.

We, therefore, move that this resolution be not adopted. (Motion adopted)

RESOLUTION No. 15, introduced by the Kendall County Medical Society. This resolution seems to desire a positive program of general welfare. In this approach it seems somewhat afield from medical interest. Your reference committee, in view of this circumstance, recommends that the resolution be not adopted. (Motion adopted)

Your reference committee believes that the Kerr-Mills bill is to be preferred over the King-Anderson Bill or other approaches we are threatened with. In this, we are joined by the AMA and the Illinois State Medical Society as stated in the first "WHEREAS" of this resolution. The opposition of Kendall County to this proposal has been made a matter of record. It is now in the domain of public knowledge. We are further advised by a member of the Kendall County Medical Society that the 60% of the membership present and voting unanimously consisted of five members. Believing as we do in majority rule, we recommended that this resolution be not adopted. (Motion adopted)

RESOLUTION No. 21, introduced by the Chicago Medical Society, having its origin in the Jackson Park Branch, deals with a proposed state law which will repeal the requirement of U. S. citizenship before being licensed to practice medicine.

Your Reference committee is advised that this is in essence, H.B.140 which is now pending in Springfield awaiting further hearing. We believe that no action is required on this resolution in view of the status of the pending legislation and that the wishes of the Jackson Park Branch will soon become a law. A poll of your committee however, revealed the feeling that it would be highly desirable if every doctor practicing medicine in the State of Illinois was a citizen of the country providing him the opportunities he desires.

DR. TICHY: It has taken the Chicago Medical Society and other component medical societies of this state many years to put over the idea of citizenship. Most of the states of the United States have this proposal in their laws.

Now, for some unknown reason, political or otherwise, we have dumped all our efforts over twenty years in a matter of a few minutes and backed up some political astringent.

I am unable to understand why a physician who professes to practice in the State of Illinois should not at least qualify for citizenship, either by obtaining first papers or by actual citizenship before setting up the practice of medicine.

DR. ADAMS: I think I should attempt to defend the resolution, especially as it originated in our branch.

The proportion of physicians to population in the State of Illinois is falling. Some of us think that this is not desirable. This country is not educating enough physicians to provide the continuation of the proportions which we believe are necessary.

Apparently, there is available, relative to examinations of foreign doctors, standards for which I believe we have basic rules for setting out the incompetency of men taking the examinations and thus not qualifying those who do not qualify. I have heard some comments to the fact that perhaps it is a little too factual, that perhaps the standards are too high.

I believe we need these foreign physicians. They must spend five years in this country before they are eligible for citizenship. If they choose to practice in Illinois, then they must do something else during this five-year period while waiting for the time limit to expire under which they can become citizens.

I also believe that physicians ought to become citizens but I believe very strongly in the point of the resolution, that they should have an opportunity to practice if they are capable before they are able to become citizens.

DR. GREEN: I would like to bring you up to date on a legislative factor concerning this citizenship requirement. This was put into the law at the last session of the legislature and, of course, there was a tremendous reaction against it among some of the legislators. Therefore, they put through a bill to repeal it in toto.

The Medical Society legal department at this time is in the process of trying to retain in this repeal here the factors that an applicant has to speak English and to follow through with the intent to become a citizen. There is also a note in there that if he does not follow through in due time that his license will be repealed. This, I think, should be acceptable to all concerned. It would obviate the necessity of taking any definite action on this resolution.

MR. OBLINGER: In the last session of the General Assembly, we put in Senate Bill 666, which asked for a citizenship requirement. The bill was defeated in a House Committee and on the last two days of the session the members of the Medical Practice Act Commission found an amendment on another bill which in effect put in citizenship. There was a great deal of dissension and unhappiness in the General Assembly over this maneuver and so one of the first problems we had in the 72nd General Assembly was this problem of repeal of the citizenship requirement.

They put the bill into the House. It was heard in committee and we were resoundingly defeated when we offered the two amendments; one which we call a condition subsequent and the other a language requirement.

What we mean by "condition subsequent" is that when a doctor becomes eligible for United States citizenship and he does not take out a citizenship, he therefore becomes ineligible for re-registration under the Medical Practice Act.

The bill went through a hard fight in the House. We lost in the House and then it went to the Senate and about a week ago we were able to hang the "condition subsequent" on to House Bill No. 140. However, we lost the language requirement.

The bill is now on its second or third reading in the Senate but undoubtedly the bill will be voted on in the Senate. It goes from there, with the amendment, back to a reference committee between the House and Senate, at which time the matter will be resolved.

We are supporting the "condition subsequent" and I am hopeful that we will be able to get this for you.

(The question was called for, the motion was then voted upon and was declared to be carried.)

RESOLUTION No. 28 was introduced by Jackson County Medical Society, dealing with an involved medico-legal matter and representing an evolutionary step in our professional lives. (Adopted)

RESOLUTION No. 34 is introduced by a special committee of the Chicago Medical Society consisting of Doctors Walter C. Bornemeier, George Turner and L. F. Mammoser, and a special committee of the Illinois State Medical Society consisting of Doctors E. A. Piszczek, Andrew Brislen and Eugene McEnery. It deals with the establishment of a new medical school. (adopted)

RESOLUTION No. 40 deals with making membership in the Illinois State Medical Society available to non-citizens. The adoption of this resolution would require a revision of our Constitution making possible such a membership. With this circumstance in mind, we recommend that this matter be referred to the Council for study and such action as considered necessary. (Adopted)

Reference Committee on Constitutions and Bylaws
Dr. William H. Schowengerdt, Chairman

Your reference committee to receive and report on the suggested changes in the Constitution and Bylaws met in the executive session following an open hearing in the Time Room No. 110, on Monday morning May 15, at 9:30 a.m. and wishes to report as follows:

Suggested change: ARTICLE I — NAME — The name and title of this organization shall be "The Medical Society of Illinois."

Your committee after careful consideration of the proposed name and the initials thereof which would be the same under the above suggested name as those of the Illinois Medical Service, or if changed to Illinois Medical Association would have the same initials as the Illinois Manufacturers Association, recommend that this portion of the report be disapproved.

Therefore, ARTICLE I — NAME will read as follows:

The name and title of this organization shall be the Illinois State Medical Society. (Adopted)

Suggested changes: ARTICLE II — Purposes of the Society — The purposes of this Society are to promote the science and art of medicine, the protection of public health, and the unity of the medical profession; to promote similar interests in the component societies; and to unite with similar organizations in other states and territories of the United States to form the American Medical Association. The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

Your committee recommends that the words in lines 3 and 4 "and the unity of the medical profession" be deleted.

Add in line 3 and 4 the following words after the words "public health" — "To elevate the standards of medical education and to unite the medical profession behind these purposes".

So that Article II — Purposes of the Society — will now read as amended:

ARTICLE II PURPOSES OF THE SOCIETY.

The purposes of this Society are to promote the science and art of medicine, the protection of public health, to elevate the standards of medical education and to unite the medical profession behind these purposes; to promote similar interests in the component societies, and to unite with similar organizations in other states and territories of the United States to form the Amercan Medical Association. The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

I move the adoption of this portion of the report as amended. (Adopted)

Suggested changes: ARTICLE IV — COMPOSITION OF THE SOCIETY — Section 1. Members.

a. The active members of the Society shall consist of members, emeritus members, retired members, intern members, and resdency members. Active members shall enjoy full privileges which include membership in the American Medical Association.

b. Honorary members shall be those physicians of Illinois or other states or foreign countries who have risen to prominence in the profession and who may be elected by nine-tenths vote of the House of Delegates at any annual meeting. They shall not be entitled to vote or hold office, nor shall they be counted as members in determining the number of delegates to the American Medical Association.

Section 2. Qualifications for Membership.

a. Every physician duly licensed and registered in the State of Illinois to practice medicine in all of its branches who is a graduate of an approved medical school, a resident of the State of Illinois and a citizen of the United States, who is of good moral character and professional standing, and a member of his component medical society, shall be eligible for membership.

b. The following shall also be eligible if approved and recommended by the component medical society:

(1) Every physician serving at headquarters as a full time employee of the American Medical Association;

(2) Physicians serving as medical officers in the United States Army, Navy, Air Force, the U. S. Public Health Service, and those serving full time in the Veterans Administration who are members of the component society, so long as they are engaged actively in their respective service, and thereafter, if they have been retired on account of age or physical disability, or after long and honorable service under the provision of an Act of Congress.

c. Physicians otherwise eligible for membership, and licensed in one of the States of the Union, but not licensed in Illinois, and who are not engaged in the active practice of medicine, but otherwise employed in an allied medical activity which does not require licensure, shall be eligible for membership if approved and recommended by the component medical society and approved by the Council.

Section 6 — Residency Members

Paragraph 3. A residency member must be a graduate of a medical school approved in the United States or Canada. . .

Section 7 — Guests

Your committee recommends the following changes:

Section I (a) —add title: "Active Members"

Section I (b) — add title: "Honorary Members"

Section 6, paragraph 3 line 3, delete the words "or Canada"

So that ARTICLE IV — COMPOSITION OF THE SOCIETY will read as amended:

ARTICLE IV — COMPOSITION OF THE SOCIETY.

Section 1. Members.

(a) Active Members. The active members of this society shall consist of members, emeritus members, retired members, intern members, and residency members. Active members shall enjoy full privileges which include membership in the American Medical Association.

(b) Honorary Members. Honorary members shall be those physicians of Illinois or other states or foreign countries who have risen to prominence in the profession and who may be elected by a nine-tenths vote of the House of Delegates at any annual meetings. They shall not be entitled to vote or hold office, nor shall they be counted as members in determining the number of delegates to the American Medical Association.

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(b) The following shall also be eligible if approved and recommended by the component medical society:

(1) every physician serving at headquarters as a full time employee of the American Medical Association;

(2) physicians serving as medical officers in the United States Army, Navy, Air Force, the U. S. Public Health Service, and those serving full time in the Veterans Administration who are members of the component society, so long as they are engaged actively in their respective service, and thereafter, if they have been retired on account of age or physical disability, or after long and honorable service under the provision of an Act of Congress.

(c) Physicians otherwise eligible for membership, and licensed in one of the States of the Union, but not licensed in Illinois, and who are not engaged in the active practice of medicine, but otherwise employed in an allied medical activity which does not require licensure, shall be eligible for membership if approved and recommended by the component medical society and approved by the Council.

Section 6 becomes Section 4 "Retired Members"
Section 4 "Intern Members" becomes Section 5
Section 5 "Residency Members" — becomes Section 6 paragraph 3 will read as amended:

"A residency member must be a graduate of a medical school approved in the United States, have a degree of Doctor of Medicine or its equivalent, must be a member in good standing of his component society and must be a citizen of the United States.

Section 8 "Guests" — becomes Section 7

I move the adoption of this portion of the report as amended. (Seconded)

DR. HOPKINS: All throughout the report of this Reference Committee we are dealing with the requirement of citizenship as a requisite for membership in the State Society. Realizing that the requirement of citizenship may possibly be rescinded at this session of the legislature, has any committee given any thought to the people who are political refugees with respect to their eligibility as members of the Society?

I am not posing any opposition to this report of the committee but I am only asking for information in this respect.

DR. BORNEMEIER: Relative to the matter of citizenship, there are two things to consider:

One of them is citizenship with respect to obtaining a license to practice in Illinois. The matter we are concerned with here is citizenship in order to belong to the component state medical society.

The citizenship requirements to belong to the Illinois State Medical Society have been in this Constitution and Bylaws for a great many years. It was not affected by the Bylaws passed a couple of years ago and it will not be affected by any law that may be repealed this time. Therefore, citizenship, as far as membership in the Society is concerned, was brought before the Reference Committee because our Committee on Constitution and Bylaws made no recommendation of any change as far as citizenship goes relative to membership in the Society.

Relative to this entire Article IV, on the Composition of the Society, we merely rearranged it and we made only a couple of suggested changes to which the Reference Committee added three suggestions.

One of them was that we put a title on "Active Members", and they would underline that and then they would put a title under "Honorary Members" and then, from the words "or Canada" on, we made only one change, besides rearranging it. Therefore, as I say, the matter of citizenship actually was not before the Reference Committee to consider at this time and if anybody in this House believes that we should delete from the Constitution and Bylaws of the Illinois State Medical Society the requirement of citizenship, then that matter should be introduced into the House and referred to the Committee on Constitution and Bylaws, who would then make some recommendation about it. It would then go to the Reference Committee and come before this House. (Motion adopted)

DR. SCHOWENGERDT: There were no other submissions, except a resolution which laid over from last year and since the first reading of the proposed changes was on Sunday night, your committee had no right to consider any other portion of the Constitution and Bylaws except that which was submitted by the Constitution and Bylaw Committee and that one amendment or resolution.

We now come to Article V as follows:

ARTICLE V — HOUSE OF DELEGATES — Suggested Changes:

Section 2. Composition (add title)
Section 3. Property and Funds (add title)
Section 4. Quorum (add title)

So that ARTICLE V — HOUSE OF DELEGATES, as amended will read as follows:

Section 2. Composition. The House of Delegates shall consist of: a) delegates elected by the component societies; b) the officers of the Society; c) the past presidents; d) both general officers and members of the House of Delegates of the American Medical Association from the Illinois State Medical Society.

Section 3. Property and Funds.

All recommendations of the House of Delegates dealing with the acquisition or disposal of property of any kind, or with the appropriation or expenditure of funds, must be approved by the Council.

Section 4. Quorum.

Fifty delegates representing not less than twenty counties shall constitute a quorum for the transaction of business.

I move the adoption of this portion of the report as amended. (Adopted)

ARTICLE VI — THE COUNCIL — Recommended changes:

Section 1. Composition (add title) and in line 8 add as follows: six shall be chosen from district number three and one from each of the other ten districts, these districts of the geographical areas as of May, 1946, see map of Councilor Districts attached.

Section 2. Executive Administrator (add title)

Section 3. Funds and Expenses.

No person shall expend or use for any purpose money belonging to the Society without the approval of the Council.

All acts of the House of Delegates involving the expenditure, appropriation or use in any manner of money, or the acquisition or disposal in any manner of property of any kind belonging to the Society, must be approved by the Council before same shall become effective.

The Council shall formulate rules governing the expenditure of money to meet the necessary running expenses and fixed charges of the Society as well as such other rules governing its actions as it may deem necessary or desirable.

Funds may be appropriated to encourage scientific investigation, medical education, and for any other purpose deemed proper and approved by the Council.

Section 4. Councilor-at-large. (add title)

Each year the retiring president of this Society .....

Section 5. The Benevolence Fund. (add title)

Section 6. Quorum.

Ten members of the Council shall constitute a quorum for the transaction of business.

Section 3 becomes first paragraph of new Section 3
Section 4 becomes second paragraph of new Section 3
Section 5 becomes third paragraph of new Section 3 except for the last sentence.
Section 8 becomes fourth paragraph of new Section 3
Section 6 becomes new Section 4
Section 7 becomes new Section 5

ARTICLE VI — The Council as amended will now read:

ARTICLE VI — THE COUNCIL.

Section 1. Composition. The Board of Trustees, or as in this Constitution and By-laws designated THE COUNCIL, whose duties are executive and judicial, shall consist of sixteen councilors elected by the House of Delegates, (six shall be chosen from district number three and one from each of the other ten districts, these districts of the geographical area as of May 1946, and one councilor-at-large (the retiring President, who shall serve a term of one year), the President, the President-Elect and Secretary-Treasurer. The Vice-Presidents, the Presiding Officer and the alternate Presiding Officer shall attend the meetings, (including executive sessions) with the right of discussion, but without the right to vote. Besides its duties mentioned in the bylaws, it shall have charge and control of all property belonging to this Society of whatsoever nature, and of all funds belonging to this Society from whatsoever source.

Section 2. Executive Administrator. The Council shall employ an Executive Administrator whose duties shall be determined by the Council. He shall be responsible to the chairman of the Council. The Council shall also employ such other people as are needed for the conduct of the affairs of the Society.

Section 3. Funds and Expenses. No person shall expend or use for any purpose money belonging to the Society without the approval of the Council.

All acts of the House of Delegates involving the expenditure, appropriation or use in any manner of money, or the acquisition or disposal in any manner of property of any kind belonging to the Society, must be approved by the Council before same shall become effective.

The Council shall formulate rules governing the expenditure of money to meet the necessary running expenses and fixed charges of the Society as well as such other rules governing its actions as it may deem necessary or desirable.

Funds may be appropriated to encourage scientific investigation, medical education and for any other purpose deemed proper and approved by the Council.

Section 4. Councilor-at-large. Each year the retiring president of this Society shall automatically become a member of the Council for a period of one year. He shall be designated as a "Councilor-at-large".

Section 5. The Benevolence Fund. Each year the Council shall appropriate from the funds of this Society such sum or sums as it may deem proper to be held in a fund to be known as the "Benevolence Fund".

This fund is established and shall be used only for the assistance or relief of needy members of this Society, their widows, widowers or minor children.

The assets shall be held in the treasury of this Society in a separate fund. Donations or bequests to the Benevolence Fund automatically become a part of these assets.

Section 6. Quorum. Ten members of the Council shall constitute a quorum for the transaction of business. (Adopted)

ARTICLE X—DUES AND EXPENSES—Suggested changes:

Section 2. Teaching, Research and Administrative members in the full time employment of any of the approved medical schools in Illinois shall pay dues at a 50% rate unless such physician is receiving $12,000 or more annual salary.

Also, the Council shall be authorized to give similar consideration on an individual basis to members engaged in full time teaching or research in a not-for-profit institution upon recommendation of the component society. The Council shall recommend similar consideration by the A.M.A.

Section 3. Physicians in the private practice of medicine shall be given a 50% reduction in dues during the first year of practice.

Section 4. Physicians approved for membership after June 30 shall pay one-half of the annual dues for that year.

Section 5. The Council may authorize the remission of dues of any member on recommendation of his component society for good reason. In such cases, the secretary shall recommend remission of dues by the American Medical Association.

Your reference committee recommends that Section 2, paragraph 1, line 4, the words following "a 50% rate" be deleted, and add the following after the words "a 50% rate"—"upon nomination by the dean of the medical school, and upon recommendation of the component society".

ARTICLE X — DUES AND EXPENSES—as amended, will now read:

ARTICLE X — DUES AND EXPENSES.

Section 1. Annual dues. Funds shall be raised by an equal per capita assessment on each component society. The amount of the dues shall be fixed by the House of Delegates and shall include the dues and/or assessments approved by the House of Delegates of the American Medical Association.

These annual dues shall include the annual subscription to the Illinois Medical Journal which shall be at least fifty percent of the regular subscription price of the Journal.

Section 2. Teaching, Research and Administrative members in the full time employment of any of the approved medical schools in Illinois shall pay dues at a 50% rate upon recommendation of the component society.

The Council shall also be authorized to give similar consideration on an individual basis to members engaged in full time teaching or research in a not-for-profit institution upon recommendation of the component society. The Council shall recommend similar consideration by the A.M.A.

Section 3. Physicians in the private practice of medicine may be given a 50% reduction in dues during the first year of practice upon recommendation of their component society.

Section 4. Physicians approved for membership after June 30 shall pay one-half of the annual dues for that year:

Section 5. The Council may authorize the remission of dues of any member on recommendation of his component society for good reason. In such cases the secretary shall recommend remission of dues by the American Medical Association.

I move the adoption of this portion of the report as amended. (Seconded)

DR. SWEENEY: If this is passed, will these members be used in determining the total membership of the Society so that delegates to the American Medical Association may be determined by this House?

PRESIDENT HESSELTINE: They are members.

DR. SULLIVAN: I was rather interested in how the committee arrived at the rates of $12,000 as the limit at which the dues should be raised to the full standards? In other words, why not $10,000, why not $9,000? I am sure that a lot of general practitioners, who are the backbone of this organization, who do not have possibly $8,000 or $9,000 after taxes, would be discriminated against. Why are they discriminated against? What is the advantage to the Society of having these people in the Society at a reduced rate? What will they contribute to the Society which the ordinary practicing physician paying full dues does not?

DR. BORNEMEIER: If you will read your report, you will see that we have left out the $12,000 completely. There is no figure mentioned in the Section that we are asking you to adopt. There is no amount of money mentioned. (Motion adopted)

DR. SCHOWENGERDT: We now come to the revision of the Bylaws. The first has to do with Chapter V—House of Delegates—suggested changes as follows:

Section 3 ADD a paragraph two:

The term of office of a delegate shall begin January 1, and shall be for two years, or until his successor has been elected. Component societies with one delegate only may elect for one year.

CHAPTER V — HOUSE OF DELEGATES, as amended will read Section 1. the same

Section 3. Each component society shall be entitled to send to the House of Delegates each year, one delegate for each 75 members, and one for each major fraction thereof; but each component society which has made its annual report and paid its assessment as provided for in this Constitution and By-laws, shall be entitled to one delegate.

The term of office of a delegate shall begin January 1, and shall be for two years, or until his successor has been elected. Component societies with one delegate only may elect for one year. (Adopted)

CHAPTER VI — ELECTION OF OFFICERS as amended will read:

CHAPTER VI — ELECTION OF OFFICERS.

Section 1. All elections shall be by ballot except where there is only one candidate for a given office; then election may be by voice vote.

The majority of votes cast shall be necessary to elect.

Section 2. The election of officers shall follow immediately the reading of the minutes of the last regular meeting of the House of Delegates. (Adopted)

CHAPTER VIII — THE COUNCIL — Suggested changes:

Section 3 — in the last (third) paragraph this should read:

Each of the above named committees shall consist of at least three members serving for three years, an equal number to be elected annually at a meeting of the delegates from his district, called by the Councilor during the annual meeting. The chairman of the Committee shall be designated by the delegates.

CHAPTER VIII as amended will read:

Section 3 — Each councilor district which is composed of more than one county, shall have an Ethical Relations Committee, a Grievance Committee and a Committee on Prepayment Plans and Organizations. These district committees shall function at the request of and in behalf of counties that do not have similar committees.

The report of the recommendations and findings of these committees shall be made to the component society involved for action at the next regular meeting of the component society. The councilor for the district shall be an ex-officio member of these committees and shall report to the Council the action taken by the component society on the committee report.

Each of the above named committees shall consist of at least three members serving for three years, an equal number to be elected annually at a meeting of the delegates from his district, called by the Councilor during the annual meeting. The chairman of the committees shall be designated by the delegates. (Adopted)

DR. SCHOWENGERDT: We next go to Chapter IX — entitled "Committees", with recommended changes as follows:

Section 2 (third paragraph) Ex-officio members of this committee shall include the president, the president-elect, the chairman of the Council and the immediate past president.

CHAPTER IX — COMMITTEES — will read as amended:

Section 1 — the same

Section 2. The committee to program the Annual Meeting shall consist of at least nine members, one third to be appointed annually by the Council to serve a term of three years, except that when first constituted, three members shall be appointed for terms of three years, three for terms of two years, and three for terms of one year.

It shall be the duty of this committee to coordinate the programs for the General Assemblies, the section meetings and the scientific exhibits at the annual meeting. It shall recommend to the Council a secret committee to make the awards to the scientific exhibitors.

Ex-officio members of this committee shall include the president, the president-elect, the chairman of the Council and the immediate past president.

Section 3-10, no change. (Adopted)

DR. SCHOWENGERDT: We now come to Chapter XIII — "MISCELLANEOUS", the recommended changes which reads as follows:

Section 4 — Paragraph 1 — delete
Paragraph 2 — delete
Paragraph 3 — The Council shall be entirely responsible for the selection of ethical exhibits for the annual meeting.

Section 5. The fiscal year of this Society shall be from January first to December thirty-first inclusive.

ADD A NEW SECTION 7.

Section 7. Roberts Rules of Order, Revised, shall be the guide for procedure when not in conflict with the Constitution and Bylaws.

CHAPTER XIII, as amended will now read:

CHAPTER XIII — MISCELLANEOUS

Section 1 — no change

Section 2 — no change

Section 3 — no change

Section 4 — The council shall be entirely responsible for the selection of ethical exhibits for the annual meeting.

Section 5. The fiscal year of this Society shall be from January first to December thirty-first inclusive, effective January 1, 1961.

Section 6 — no change.

Section 7. Roberts Rules of Order, Revised, shall be the guide for procedure when not in conflict with the Constitution and By-laws. (Adopted)

DR. SCHOWENGERDT: I would now like to call your attention to the next paragraph:

Your committee, with the aid of the members of the Constitution and Bylaws Committee, Mr. John W. Neal, legal counsel, Dr. M. Mijanovich and an opinion prepared by Mr. Walter Oblinger, presented by Dr. Bornemeier, — recommended that the resolution as presented by the McHenry County Medical Society at the annual meeting in 1960, be not adopted. (Motion adopted)

Reference Committee on Reports of Council Committees
Dr. William H. Whiting, Chairman

ADVISORY COMMITTEE TO THE DEPENDENTS MEDICAL CARE PROGRAM: The question of reduction in services covered was discussed and the information presented that fiscal limitations were responsible and that emphasis is placed on care of dependents as much as possible in available military medical facilities. Your reference committee approved the fact that no complaints concerning payment for services were presented to the committee by physicians or county societies during the year. (Adopted)

ADVISORY COMMITTEE TO THE ILLINOIS PUBLIC AID COMMISSION: During these presentations and the discussion of the effectiveness and discretion of this committee's activities were impressively demonstrated. In spite of this it is still apparent that many physicians practicing in Illinois do not understand the true role of the Advisory Committee. This Committee is only advisory in its relationship to the Commission and can only recommend to it such actions as will most satisfactorily accomplish the mutual aim or physicians and the commission to provide essential medical services at a minimum cost within the medical care budget. The committee is not dictatorial but interpretive and its functions to suggest policy to the commission concerning the problems of physicians in providing this care. Inasmuch as physicians' services are compensated on a fixed fee schedule the adjustment of fees is always made in consideration of this schedule.

During the deliberations of the Advisory Committee in 1960-1961 the determination of a fee schedule for services of anesthesiologists was thoroughly considered with the Sub-committee on Anesthesiology and the medical department. The Advisory Committee agreed with the principle that a fair negotiation of fees was necessary and has so recommended to the commission and your reference committee concurs. The primary problem, however, revolves upon payment of hospital services and the fact that many hospitals include anesthesia services in their reimbursable costs, and the Commission takes the position that payment cannot be made twice for the same service. In those unusual cases where prolonged, complicated procedures are concerned payment has been made by the Commission upon the recommendation of the Advisory Committee commensurate with the time and skill involved and in consideration that this is basically a minimum fee but this does not solve the problem of basic fees. The Sub-committee on Anesthesiology has been advised of these matters and encouraged to approach the hospitals for an adjustment of the payment practices.

The chairman, Dr. Compton, emphasized the co-operation of the members of his committee in meetings and in consultation with county societies and individual physicians in an effort to solve problems that arose because of misunderstanding of the rules of the commission. The serious problem of the rising costs of prescribed drugs was pointed out and we wish to emphasize this and to

point out that the methods of control now in use, the prescription form and the regulations concerning it, have been at least partially successful and to suggest that individual members can be of real assistance to the committee if concrete proposals are offered and carping criticisms held in abeyance.

The attention of this House is called to the fact that participating physicians in Cook County are not paid for hospital services provided directly by them in the private hospitals of Cook County although they are paid for office visits and services and home calls. The reasons responsible for the initiation of this practice no longer persist and the Advisory Committee has concurred in the recommendation of the Cook County Committee that payment for these services should be made.

Your reference committee wishes to commend this hard working committee for the accomplishments of the past year and especially the chairman, Dr. Compton, for an exceptional job done in the interest of all of the physicians of Illinois. (Adopted)

ADVISORY COMMITTEE TO THE MEDICAL ASSISTANTS ASSOCIATION:

Dr. Carl E. Clark, chairman, was present and emphasized the fact that this is an ethical and cooperative group with the best interests of physicians foremost in their considerations and the reference committee concurs in his recommendation that every effort should be made by physicians to assist the association and to promote its expansion. There have been efforts made by unethical groups to organize these people for monetary return and this group deserves our support to prevent these abuses. (Adopted)

LIAISON COMMITTEE TO THE AMERICAN LEGION: None submitted

ADVISORY COMMITTEE TO CIVIL DEFENSE: During the discussion it was brought out that the Disaster Medical Care Program is now being implemented by the U.S. Public Health Service and by publication of a handbook for non-professional persons and indoctrination courses some progress is apparent It is, therefore, to our best interests that this committee continue to funcion and we commend them for past interest and hope for more general concern of the problem in the future. (Adopted)

CORONERS COMMITTEE: The Committee was encouraged to see that progress continues to be made in the efforts to improve the services of the Coroners offices throughout the State of Illinois in light of modern forensic medical knowledge. We wish to commend the Committee for its participation in this most desirable program. (Adopted)

ADVISORY COMMITTEE TO SELECTIVE SERVICE: Dr. Carl F. Steinhoff, chairman, pointed out that appropriate encouragement of your physicians has begun to solve the procurement problem. Your Reference Committee wishes to compliment Dr. Steinhoff and his committee for effective assistance to all concerned in this important field and to encourage them to continue in the interests of organized medicine to assure the military services the needed trained physicians. (Adopted)

ADVISORY COMMITTEE TO THE VETERANS ADMINISTRATION:

We were impressed with the fact that the veteran continues to be a special class of citizen in relation to medical services for non-service connected illness and injury.

Your reference committee concurs in the opinion that the practicing physician should continue to use his best influence and professional competence to provide the most thorough medical services to all people and to restrict referral of veterans to those persons with non-service connected disabilities whose finances are such that adequate care is only available through these special facilities. (Adopted)

ADVISORY COMMITTEE TO THE WOMANS AUXILIARY: Not available. The report of Mrs. Charles L. Wunsch was read by all with interest and warm appreciation for the enthusiastic support she has expressed. She begins her report as follows: "The feeling of pride and happiness which I am confident you share with me, in the recognition and accomplishments of your Auxiliary is the result of the interest and efforts of our membership and the friendliness that has been displayed by each and every member." This statement movingly expresses the appreciation of your reference committee and we are thankful for the fine support our invaluable wives have provided to us in the fields of politics, social relationships and personal support. Let us not underestimate the power and influence they can wield in our present effort to stem the tide of reckless abandonment of established principles and effective methods in the economy of our practice and be humbly grateful. We do not have to go this difficult path alone." (Adopted)

RESOLUTION NO. 35

It is the conviction of the reference committee that the intent and meaning of this resolution have been covered elsewhere in the report and that the resolution is unnecessary because the principles involved have already been firmly recommended by the Advisory Committee to the Illinois Public Aid Commission. We recommend that this resolution be not adopted. (Motion adopted)

Reference Committee on Reports of Council Committees
Dr. John R. Wolff, Chairman

AMERICAN MEDICAL EDUCATION FOUNDATION: The American Medical Education Foundation is providing an excellent medium for the collection of funds by donation and their distribution to the medical schools of our country. Illinois has long been a leader in the methods of donating to this foundation. Your reference committee hopes that the Illinois State Medical Society will continue to provide funds to the foundation through the collection of dues. You will recall the report of Dr. Lull, the President of the American Medical Education Foundation, at the first meeting of the House of Delegates and the splendid feeling that existed as our money was distributed to the Deans of the Medical Schools in Illinois.

The supplementary report gives the figures as to the amount which Illinois physicians are contributing to the foundation. The Chairman of this Council Committee, Dr. Arkell Vaughn, has his fingers on the pulse of the American Medical Education Foundation. We hope that he will continue in this capacity. (Adopted)

THE COMMITTEE ON AGING:

The committee and its active chairman demonstrate a youthful vigor and great industry which has led Illinois to move forward on the problem of medical care of the aged. The report of this committee is filled with facts and demonstrates not only their interest in the problem, but what they are doing and what you, as Illinois physicians, are doing to bring about our goals for excellence in medical care for the aged. This is an ever continuing program and one that we must all participate in with vigor and enthusiasm. (Adopted)

THE AD HOC COMMITTEE (OVER 65)

As you recall, early in 1960 enormous pressures were brought to bear to have the Forand Bill reported favorably to the House of Representatives of the Congress of these United States by the House Ways and Means Committee. This was an emergency. It was so recognized by the Council of your state society. This Council acted with vigilance and acted quickly. The Council recognized this responsibility in leading your society and the physicians of this state to action. We should be thankful that the Council chose to act in this manner. After all, the main function of the Council of the Illinois State Medical Society is not only to act on the policies set forth by this House of Delegates, but to recognize the existence of an emergency and so proceed. This they did. Naturally this was not looked upon with extreme favor in all quarters

when the action was first taken. Not all of us recognized the dangers that existed, the urgency of the situation and not all of us agreed as to the proper method. This ad hoc committee appointed by the Council has reviewed the many resolutions pertaining to the action of the council. They present us with a resolution which reads in essence: BE IT RESOLVED that the Council be requested to consult with and inform the Society membership to the greatest possible extent in all important matters and not to make policy decisions except in emergency situations and that the good faith of the Council in these matters be recognized, and that while the situation shall not be deemed a precedent for the future, the actions of the Council with respect to the existing Over 65 Plan in Illinois are ratified and approved. Your Reference Committee wholly concurs with this resolution and approves its adoption. (Adopted)

THE AD HOC COMMITTEE ON THE MILLS KERR BILL

When the Kerr-Mills bill was passed by the Congress of the United States, signed by the President in October, 1960, the Ad Hoc Committee was appointed by the President of our Society and the Chairman of the Council to look into the problems of implementing this legislation in Illinois. This Committee's actions have done much towards bringing this legislation before our State Legislature. The Committee went into all questions concerning administration of the Kerr-Mills act, consulted with the IPAC (the designated state agency to administer this program) and presented legislation before the state legislature. With the introduction of this bill before the State Legislature, the actions of the Ad Hoc Committee were culminated. The problem of stimulating the passage of this bill and aiding in the administration was turned over to the Medical Service Committee of the State Society and the discussion of this will appear before this House as presented by the Medical Service Committee. Your Reference Committee recognizes that this Ad Hoc Committee on the Kerr-Mills Bill performed a remarkable function. We are indebted to the members of this committee and its Chairman for their prompt action and for their success in introducing this legislation into the State Legislature. They have performed their duties diligently and we owe them a vote of thanks. (Adopted)

COMMITTEE ON CANCER CONTROL

This Committee is led by a vigorous Chairman and the Committee has been exceedingly active. The report is brief but right to the point. Incidentally, this report and the manner of its presentation should serve as an example for other committee chairman to present a report which contains a lot of meat and very little dessert. The four recommendations suggested by the Cancer Committee are excellent and your reference committee concurs with these recommendations. The Chairman presented a supplementary report to the Reference Committee. Several years ago a film was produced by Doctors Joe Meigs and Lango Parsons of Boston entitled "Time and Two Women." This movie demonstrates the value of yearly examinations plus the use of the Papanicolau Smear and physiological studies in the early detection of uterine cancer. This movie has been approved not only by the American Cancer Society but by the American College of Obstetricians and Gynecologists, Chicago Gynecological Society and many other organizations. The Federated Women's Club of Chicago would like to sponsor this film and to present it before many of the Women's Clubs in the Chicago area and throughout the state. At one time they were asked to hold back on the showing of this movie, because it was felt that the pathologists would be swamped and did not have enough help technically to study the great number of Pap Smears which might be presented to them.

It is the opinion of the American Cancer Society, Illinois Division, that there is no longer a shortage of pathologists and technical help to study smears on a large scale throughout the State of Illinois. They feel that the time is right for the showing of this movie to large groups and hope that it will encourage many women to report to their physicians for examination and for the obtaining of smears. Of course such examinations and the smears will be obtained in the offices of the physicians. The Reference Committee is in sound agreement with the Cancer Society, and unanimously urges that we support the showing of this movie. (Adopted)

COMMITTEE ON CARDIOVASCULAR DISEASE:

This committee was appointed primarily to evaluate the work in this field in the State of Illinois. The report is an excellent summary of the activities of the Chicago Heart Association and the Illinois Heart Association. These organizations should be well supported. They are leaders in research on cardiac disorders in the presentation of information to the public and in aiding the education of physicians. The Cardiovascular Committee urges support of these associations, and our committee concurs. (Adopted)

(NOTE: Lake County's Annual Boyd Memorial Heart Lecture is in addition to those mentioned.)

ETHICAL RELATIONS COMMITTEE:

This report concerns two topics. The first is that of an appeal involving three physicians which was heard by the Committee during the past year. As a result of this hearing the committee suggests that the Illinois Medical Society prepare a handbook containing not only the codes of ethics but examples of the practical application. We agree that this might be of value to the members of the Society. We ask that this suggestion be considered carefully by the Council and so implemented according to their judgment.

The second portion of this report concerns two resolutions which originated with the Illinois Pharmaceutical Association, and which were referred to the Ethical Relations Committee by the Council. It would appear that the Ethical Relations Committee is in the process of studying these resolutions, and we too urge each of you to read carefully this portion of their report; and, we recognize that the Ethical Relations Committee will continue their discussions with the Illinois Pharmaceutical Association concerning the resolutions, and that they may have a further report for us in the future. (Adopted)

COMMITTEE ON EYE HEALTH:

This committee has also been an active one. House Bill 30 was enacted into law on June 30, 1959 amending the school code by providing for a compulsory vision examination of children in the first through ninth grades. This committee was organized in an effort to suggest the form for this ocular examination. The committee did their work and this was accomplished. A second issue presented to this committee concerns the medical aspect of contact lenses. The committee has been active in initiating an educational campaign to doctors of the state concerning this program. We hope that this Eye Health Committee will continue their activities of this most important field. (Adopted)

FIFTY YEAR CLUB COMMITTEE:

It is always a privilege and a pleasure to hear from Any Hall and his committee. The Fifty Year Club continues to be one of the great facets of our organization. We sincerely hope that Andy Hall will continue as chairman for years and years to come and that everyone in this room will some day be a member of this great organization, the Fifty Year Club. (Adopted)

COMMITTEE ON IMPARTIAL MEDICAL TESTIMONY:

The first sentence of this report reads, "This report is one of progress." A true progress this has been. The chairman of this committee and his committee workers have done wonders in this important progressive liaison between the law and medicine. The report shows you what can happen when a devoted group led by a devoted chairman strive diligently to improve the administration of justice. Not only has the principle of impartial medical

testimony been accepted by both medicine and law, but it is now in actual use in some of the courts of our state. We are certain that Dr. Levinson and his committee will continue their good work and that the wedding of law and medicine will produce many children, all with a first name of Justice. (Adopted)

RESOLUTION No. 16:

Your Reference Committee read with interest this resolution. It states certain basic principles regarding the rights of man. We fail to find where it has any significance relative to the actions of the House of Delegates. We, therefore, recommend that this resolution be received and filed but not published. (Adopted)

RESOLUTION No. 22:

The physicians who presented this resolution to the House have asked that a correction be made in the resolve portion of this resolution, where it reads: "Resolved that the AMA House of Delegates establish a Commission on the Relation of Medicine to Optometry". They request that this be changed to read: "Resolved that the AMA House of Delegates establish either a Commission or a subcommittee on the Relation of Medicine to Optometry" and that similar changes be made throughout the resolution. Your Reference Committee is in wholehearted agreement with this resolution, and we urge the adoption of this revised resolution. (Adopted)

RESOLUTIONS Nos. 23, 24 and 25:

Following the discussion of these resolutions before your Reference Committee, the members of the House of Delegates from the Will-Grundy County Medical Society, Dr. Roblee and Dr. Jessen asked that the House not consider these resolutions, and that they be withdrawn and referred back to the Will-Grundy County Medical Society for further study. Your Reference Committee is unanimous in its approval of this action. (Adopted)

Reference Committee on Reports of Council Committees

Dr. Edwin Hirsch, Chairman

INTERPROFESSIONAL COUNCIL:

The report indicates that an active interprofessional group promoted significant health projects at their monthly meetings at which your representatives participated with great interest. The committee recommends thorough exploration by the Illinois State Medical Society the development of an Illinois Associated Profession, similar to the Michigan pattern in lieu of the present committee or organization that remains controversial to many of our society members. We are pleased to have Dr. Frederick H. Falls selected as the recipient of this year's Distinguished Service award by the Illinois Interprofessional Council, for his multiple contributions to maternal health care in Illinois and across the nation and the world. (Adopted)

MATERNAL WELFARE COMMITTEE: The Reference Committee compliments the members for their continued efforts in maternal welfare. (Adopted)

COMMITTEE ON MEDICAL ECONOMICS: This committee has submitted a long supplementary report on the significance of the Relative Value principle in the professional practice of medicine. You have both statements before you. The Medical Economics Committee recommends to the Illinois State Medical Society and its constituent county societies that a Relative Value Study be conducted on a pilot basis in Illinois in 1961. To implement this recommendation, resolution No. 30 has been introduced and your Reference Committee on Reports of Council Committees No. 3 recommends it do pass. The cost of the survey will come under the approval or decision by the Council. (Seconded)

DR. SAXON: The Kendall County Medical Society is opposed to the Illinois State Medical Society's resolution proposing Relative Value Studies.

It is opposed to this because it recognizes the implementation of this study, if once achieved at the state level, will, in essence, be another freedom-eroding measure. It is socialistic in its concept and an attempt to moralize the conduct of the overcharging physician by allowing voluntary insurance purveyors for medical services a weapon to fix fees. Relative values in and out of themselves are not fees but can be used to implement fees and thereby represent a means of amputating another portion of your freedom.

In Kendall County, gentlemen, they will have to change the color of the Stars and Stripes to red before we adopt or approve of this study at any level other than the county society.

In addition, we would refuse to allow any insurance purveyor the privilege of making a profit at the expense of our freedom.

Therefore, I urge you to consider and accept the Kendall County Medical Society Resolution on Relative Value Studies.

DR. BELL: There are many stress areas in this country that have felt pressures of other groups who would price the services which doctors render. In these areas there has been necessity for giving to the profession a foundation upon which they can justify their prices for services rendered, upon which their medical societies can defend them if the fees they charge for services are challenged.

I would also say that the individual physician who bases his defense of his fee on his own estimate of his own services has no foundation for justification of that fee or for defending it.

I would like to show you just what we mean by a relative value and how it is applied to the actual fees which are now being charged by doctors to the actual allowances now being paid by Blue Shield plans.

(Slide): If you take two procedures, and you see what the general practitioner in the city charges and also what the practitioners in the county charge, you see that the ratio between these fees is a ratio of two to one. This is what a relative value study does. Then, in order to determine an exact fee, we would have to apply a coefficient or factor to these various ratios and then, from this multiplication, you would obtain a fee.

I would also like to say to you that if you will take a survey of the country, (slide), you will see that here we have a composite study which is the median fee charged. These are the median benefits provided by Blue Shield plans of all kinds and of all sizes.

If you survey these, item by item, for the thirty-two items, starting at the mid-point where the line is drawn which indicates the procedure known as "appendectomy", and give that a value of one, then you can relate all of these other high frequency services above and below that and you will see that the actual fees given by the Blue Shield Plans, if they come from service plans, are slightly higher and if they come from indemnity plans, they are very slightly lower in some areas.

DR. BORNEMEIER: I would like to call attention to the fact that we are not voting tonight upon the approval or disapproval of a Relative Value Study. The resolution says that the House of Delegates instructs the Council to proceed with a survey of procedures in representative areas within the State of Illinois, to assemble relevant information available from other states where these studies have been conducted and to utilize data obtained from both sources in developing a preliminary Relative Value Index. It further says that a copy of this preliminary proposal be sent to each member of the House of Delegates within the next six months and that this information be clearly marked, "Preliminary Proposal", so that these proposals can be studied by the recipients relative to their practical application. Then the proposals, after suitable study, modification or alteration, are to be resubmitted to this House of Delegates for approval before preparation for general distribution.

DR. C. L. REEDER: Third party financing of medical care is here to stay. It is a question of how you want this medical care to be financed.

I happen to work for the Continental Assurance Company here in Chicago, which is very deeply involved in the health insurance business and I know that the majority of the executives of the companies who are purveying medical expense coverage to the public (and I can assure you there is no thought on the part of any of these executives to try to control the medical profession or dictate to the medical profession) are basically interested in determining as near as possible a predictable cost for average illness for the average patient.

Now, if you want to default this from the private enterprise aspect of it and let the government take it over, then this is your choice. However, I very much urge you to support this move for a Relative Value Study. I think it will be to your interest to do so.

DR. BELL: I would like to request the permission of the House of Delegates to have a gentleman who works with a group that has used the value index for three years to address you at this time.

DR. BROOKINGS: I would like to say that our clinic at Urbana is an association of forty-three physicians. We operate our own hospital. We do medical care of every character—house calls, office practice, hospital practice. We do neuropsychiatric care.

We have problems within our own organization as to equitable charges. There is nothing in practice that upsets patients more than having one doctor charge a different price for the same service as does another. For this reason, therefore, we have investigated the problem of equitable fees and beginning in 1957 we used a Relative Value Schedule in our own clinic. The work that had been done in California was available and we have taken this over.

There are a few minor modifications that we found necessary. We found the urological charges a bit higher than the going charges in our area. Also, the obstetrical charges were a bit lower.

We have found that this system works and works well. It works in the sense that charges are fundamentally the same to the patients. It works well because we have no difficulty with the insurance companies if they should come and ask about certain charges. We simply tell them that we are following the Relative Value Schedule and, as a result, we have had no difficulty whatsoever. Further, it also makes it easier to explain to your patients. You point out that this is a system that is standardized, that each one is treated the same. We have found it works very well.

Therefore, I should like to support the motion of Dr. Bell, that this be studied further within the state.

DR. DOLAN: I think it is abundantly obvious that the proponents of this relative value proposition are the people who visualize a collectivist America of the future, a collectivist situation for the medical profession. I think these people openly admit that kind of an affair relative to what they have said thus far.

Now, then, let's consider the ingredients of this Relative Value Fee Schedule. This states that the physician, in order to serve his country, must join in cooperative efforts to create a national product. It emphasizes that national product which will meet the special needs of a new and imposing health insurance buyer, the organized consumer. Well, what can that mean? This is the third party dispenser of health. They continue to maintain that American medicine should stay out of health insurance but that it is to maintain, they say, a blind allegiance to the images of the past.

They also say that we, ourselves, must set up fee schedules since the present fees are inadequate and unfair; that we must set up collective values, etc.

It has been statistically proven that there is a definite relationship between the value of the various medical services offered.

As to a fixed relationship between the value of the different services, without which a relative value fee schedule would be impossible, we are asked to believe that all services are to be measured in terms of incorporated social units of labor.

DR. WHITING: I would just like to point out that if we are ever going to effectively negotiate with the Illinois Public Aid Commission for a realistc fee schedule, that there is nothing that could be of more value to these advisory committees than a Relative Value Study.

DR. GREEN: I wish to state that Winnebago County has done quite an extensive study on this matter and we have come to several conclusions. I might add that we have adopted a Relative Value Fee Schedule in our county. We have not placed any conversion factor on it.

However, we did feel that we would give a guide to a new doctor starting in the community so that his fees would be in accordance with other doctors of the community. We also felt it would protect the doctors' fees for new procedures brought about. We felt it would be easier to fill out insurance papers if we used it and had certain code numbers that we could use instead of writing out the diagnosis. We also indicated that the value of medical procedures was better established by the doctors themselves rather than having the government do it. Further, we have to have something to implement this socialized medicine or even the Illinois Public Aid and, therefore, in connection with anything of that kind, we do have something we can go to them with and tell them what is necessary and what we want. In this way everyone gets their fair share of the money which is available.

DR. BELL: This is a complicated subject. We have investigated this as thoroughly as possible in one year. We believe, with the present information available, that nobody can judge whether or not the Relative Value Study will benefit Illinois.

I wish to emphasize that we are not asking you to judge on relative values now, that we simply are asking for permission to continue the study.

(Dr. Bell moved that discussion on the proposition be extended to Thursday, May 18. The motion was not carried.)

(Dr. Saxon moved that the utilization of relative value studies be restricted to the county level. Motion was not carried.)

(The main motion was voted on and carried)

MEMBERSHIP COMMITTEE: This group composed of the five deans of the medical schools in Cook County and Chairman, Walter C. Bornemeier, Chicago and Fred C. Endres of Peoria, was organized to consider the problem of increasing the membership of our Society. Your Reference Committee urges all of you to read thoroughly the suggestions and recommendations contained in the report. (Adopted)

MENTAL HEALTH COMMITTEE: Few committees, if any, of the Society face a more significant and responsible assignment than the one you have appointed on Mental Health. A supplementary report has been submitted. The chairman of this committee, Dr. F. Garm Norbury, calls our attention to the importance of House Bill No. 951 and House Bill No. 952, which affect reorganization procedures and urges the enactment of this forward-looking legislation. The Committee on Mental Health recommends to the House of Delegates and to the Council that the Illinois State Medical Society approve in principle this legislation and urge its enactment. Your Reference Committee supports this statement. (Adopted)

LIAISON WITH THE ILLINOIS BAR ASSOCIATION

The report of progress is supplemented by a draft of proposed code as revised and approved on December 19, 1960 by the respective committees of the Illinois State Medical Society and the Illinois State Bar Association. Your Reference Committee realizes that many discussions give and take have transpired in the compilation of this code of procedure. It also recognizes that even in its more or less perfect form there can be controversy. Yet, when we appreciate the huge backlog of civil suits that clog the courts today, let us be willing to accept minor defects in the code and not build into great magnitude which is actually trivial. The Reference Committee recommends

the acceptance of this code with such changes as may realize an improvement. (Adopted)

LIAISON WITH THE ILLINOIS HOSPITAL ASSOCIATION

There has been an improved relation between the hospital groups and the committee in the work of this committee during the past year. (Adopted)

NARCOTICS AND HAZARDOUS SUBSTANCES: (Adopted)

COMMITTEE ON NURSING: An extensive report was submitted. This has in addition an extensive supplementary report. Both are before you. Actions taken in executive sessions by the Committee on Nursing deserve your close attention.

Your Reference Committee regards the nursing problem as one of the most frustrating now confronting the practice of medicine. The success of a physician in the care of his patients is determined by the good quality of nursing, especially in hospital practice. Those who have been both patients and physician know this better than the others. The present confusion in the nursing problem, as your committee concedes, needs vigorous and constructive leadership, heavily weighted by that of the medical profession. (Adopted)

COMMITTEE ON NUTRITION: (ADOPTED)

RESOLUTIONS 2, 29 and 42: All are concerned with some phase of the retirement program. Your committee recommends that a group undertake to work out the principles of these resolutions, to be combined into a single form.

(Dr. Ackley proposed an amendment: After the word "group" insert "appointed by the chair at once to work out immediately so as to obtain introduction in this session of the legislature." Amendment was defeated.)

(The question was called for, the motion to appoint a committee to work the matter out promptly was voted upon and declared to be carried.)

RESOLUTIONS 9, 10, 11 and 30.

These concern in essence a study of Relative Values as proposed by Resolution No. 30. Your Reference Committee supports Resolution No. 30 and recommends that it do pass. (Adopted)

DR. SAXON: I would like to point out a point of variation in Resolution No. 9 from Resolution No. 30. The purpose of Resolution No. 9 to inform the House of Delegates and Officers of this Society that the promulgation of fixed fees for medical services rendered by the physicians of this Society is within the province of the leadership of the Illinois State Medical Society. The Kendall County Medical Society feels that inasmuch as the Illinois State Medical Society went on record as opposing socialism in all its forms, both in and out of medicine, that it is obligatory on the part of the Illinois State Medical Society to inform its membership of the socialistic elements in freedom eroding processes of any proposal that will fix fees for medical services.

It is also obligatory on the part of the Illinois State Medical Society to decide whether a proposal is socialistic or not. This decision should then be presented to the Society on its merits for approval or disapproval, with reason for such action.

RESOLUTION No. 32 — Recommend that it do pass. (Adopted)

Dr. Hirsch: Your Reference Committee wishes to emphasize to the House of Delegates that hospital utilization is only one of several interlocked relationships: namely 1) insurance carriers, 2) labor health insurance benefits in which both labor and industry are participants, 3) hospital management and the spiraling rise in the cost of hospitalization, and 4) the physicians and their participation in these complex relationships.

Your Reference Committee suggests with emphasis that the State Medical Society designates a group, call it a Commission if you will, to explore this complex problem with 1) hospital management, 2) insurance carriers, 3) labor and 4) industries participating to formulate, if possible, basic principles for mutual understanding and operation. (Adopted)

(The session was, at eleven-ten o'clock p.m., recessed.)

Reference Committee on Reports of Council
Dr. Charles Allison, Chairman

COMMITTEE ON OCCUPATIONAL HEALTH: We agreed that implementation of the Broad program of the Congress on Industrial Health of October 10, 1960 would be quite difficult. We endorsed the decision of the committee that further study of the Workman's Compensation Act even beyond the medical point of view is indicated. In the discussion before the committee, the value of Impartial Medical Testimony was stressed, and we hope with further work the eventual adoption of Impartial Medical Testimony in the state courts of Illinois will be accomplished. We congratulate the committee on their work and the information they gave us, and we hope for further progress in these areas. (Adopted)

COMMITTEE ON PERMANENT HOME:

We congratulate the committee on the work done and the progress that has been made toward a new building. We hope that the Illinois State Medical Society will continue to work with the Chicago Medical Society in acquiring a new building. We recommend to the Council that when the Chicago Medical Society desires to proceed, that a liaison committee be appointed to work with them and proceed as fast as possible. (Adopted)

COMMITTEE ON PHYSICALLY HANDICAPPED CHILDREN: We agree with the committee that when the name of the law was changed to "Handicapped Children" from "Crippled Children", it broadened greatly the types of cases included in this group. We do not recommend that the law be broadened to include other groups, particularly asthma. (Adopted)

COMMITTEE ON POLIOMYELITIS CONTROL: The committee commends the attitude of the committee in encouraging physicians to give vaccine, even though the Illinois Public Aid Commission does not provide payment. We recommend that the committee continue to encourage the Illinois Public Aid Commission to provide preventive Medical Service. The interesting suggestion of the committee for the consolidation of some 14 committees into one Committee on Preventive Medicine and Public Health was included in the final paragraph of the report. The evaluation of this suggestion might best be made by the Council. (Adopted)

COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION AND SCIENTIFIC SERVICE: We appreciate the amount of work done and the number of meetings during the past year. We endorse, in principle, the recommendations of the committee. Since there is a committee to study postgraduate medical education we suggest that these recommendations be referred to this committee for further study. (Adopted)

COMMITTEE ON RURAL HEALTH AND STUDENT LOAN FUND: We read the report with interest and although we share the disappointment over the defection of the few, we are pleased by the observation of the fact that the program has reached the stage that it can be revolving. The supplementary report was also studied with interest. The committee hopes the criticism in the last paragraph has been directed to the program committee. (Adopted)

COMMITTEE ON SCHOOL HEALTH:

The committee strongly endorses both recommendations in this report. The committee is to be commended on the fine work they are doing in the field of athletics. (Adopted)

COMMITTEE ON TUBERCULOSIS:
The committee endorses the recommendations with the exception of the 7th recommendation. We recommend that the wording be changed from leadership in implementing them to recommending their implementation. (Adopted)

COMMITTEE ON RADIATION: We notice that the committee has started an ambitious program. We wish that the committee can be active and render service in the future. (Adopted)

COMMITTEE TO STUDY POSTGRADUATE MEDICAL EDUCATION: The report of progress has been received and we recommend its acceptance. (Adopted)

COMMITTEE ON THE SPRINGFIELD OFFICE: No written report. The committee wishes to report that the office in Springfield is now open. (Adopted)

COMMITTEE ON TRAFFIC SAFETY: This is a progress report of the completion of phases one and two of the Illinois Cornell Automotive Crash Injury Research Project and the initiation of phase three. The project appears to be progressing very well and that they are receiving good support from the physicians in the various counties. They are to be complimented upon their good work. (Adopted)

RESOLUTION #1961-19, River and Stream Pollution.
The committee recommends approval of the resolution. (Adopted)

RESOLUTION 1961-33, Establishment of a Section of Physical Medicine. The committee approves the resolution with the following modification. That the resolved portion read, NOW THEREFORE BE IT RESOLVED that a section on Physical Medicine of the Illinois State Medical Society be established. (Adopted)

RESOLUTION 1961-37, Council Resolution.
The committee endorses the purpose of this resolution. We recommend the substitution of the word "support" for the words "become active" in the third line of the fourth and fifth paragraphs. (Adopted)

RESOLUTION 1961-38, Panel Institutions.
The committee recommends disapproval for failure of supporting information. (Adopted)

RESOLUTION 1961-41, FAA Hospital Exam.
The committee recommends that approval of the resolution with rewording of the resolved to read as follows: "THEREFORE BE IT RESOLVED that this House of Delegates request the AMA to determine the reasons for rejections of these physicians and further to determine whether the assurance above is valid."
Dr. W. O. Ackley pointed out that the title of this resolution contained an error and the title was voted to be "FAA Pilot Medical Examination". With this correction, the resolution was adopted.

RESOLUTION 1961-44.
The committee approved the resolution and recommends its adoption. (Adopted)

RESOLUTION 1961-45, AMA Clinical Session.
The committee recommends the approval of the resolution with the rewording of the resolve to read as follows. "THEREFORE BE IT RESOLVED that this House of Delegates instruct its delegates to the AMA to introduce and work for the passage of a resolution that will abolish the Annual Clinical Session." (Seconded)

DR. HOPKINS: Similar resolutions have been presented to the House of Delegates on many an occasion during my time in the House of Delegates of the AMA. I have no fault to find with this resolution. I would, however, point out a few things in connection with it.
Speaking for the committee's recommendation, that the delegation from Illinois be instructed to work for the discontinuance of the Annual Clinical Conferences, I might add that there is the expense attached to it which other state societies are also subjected to.
On the other side of the picture, gentlemen, is the very great amount of work entailed, the very great number of questions and problems that arise in even our local county societies, as well as the state society council, for instance, and the Board of Trustees of the AMA also have contracts with regard to their efforts to pick up policy or determine policy. As I say, there are many questions that arise which, it seems to me, it is not often practical to carry on from year to year, whereby the Board of Trustees is saddled with the responsibility of determining policy in connection with the discontinuance of the meetings of the Clinical Sessions of the House of Delegates. Therefore, I would ask you to consider that very carefully.
I am not opposing this resolution because, certainly, policy should be determined by the delegates from the various state medical societies. However, I would ask you to be practical in considering this problem.
DR. CARROLL (Macon County): I would like to raise one small voice in the very large wilderness and say that once you have attended the Clinical Session, if you only attend it for the scientific benefit you derive therefrom, you will discover that it is by far the best session which the AMA puts on. Therefore, for this reason, I would hate to see it abolished.
DR. HAMILTON: I have questioned for the last several years and have been in favor of dropping the interim session as a general meeting. I agree most heartedly with what my friend, Dr. Hopkins says about the necessity of more than one meeting of the House of Delegates. I don't think it is fair to shoulder on the Board of Trustees all of the problems and responsibilities that are given to them and I think that the House of Delegates of the AMA should meet at least twice a year.
I am inclined to think that this is more the spirit of the resolution than it is to do away with the meeting of the House of Delegates and that assistance which they may be able to give to the Board of Trustees in formulating the policies which regulate medicine throughout the United States.
DR. ALLISON: Mr. President, I might add hereto that we felt there was no interference with the business part of the session but that his resoluion mainly was to discontinue the postgraduate session.
DR. BORNEMEIER: I would like to offer an amendment.
I move that we strike the last three lines of the "Resolved" and insert the words "give consideration to the discontinuance of the scientific portion of winter meetings", so that it will read: "That this House of Delegates instruct its delegates to the AMA to introduce and support the passage of a resolution that will give consideration to discontinuance of the scientific portion of the winter meeting".
DR. G. B. CALLAHAN: It has been obvious, from reports here, that there are members in the group who feel that there are scientific benefits to be derived from the meeting.
Further, in relation to Dr. Montgomery's comments, when you consider the public relations effect, then that $40,000 is a very reasonable advertising figure to take up in relation to advertising the AMA to a portion of the country that very rarely sees a group of doctors.
DR. SWEENEY: I would like to add my voice on the part of continuance of the clinical sessions and not support this resolution.
I also believe that the public relations values are of great benefit here. We need this. This is a time when people can read and see what doctors are doing to help the patients and, therefore, I believe the clinical session ought to be continued.
(A motion to table the resolution and its amendment was made and defeated on a standing vote.)

(There was a request to have the amendment read.)

DR. REISCH: "That this House of Delegates instruct its delegation to the AMA to introduce and support a resolution that will give consideration to the discontinuance of the scientific portion of the winter meeting." (Adopted)

DR. M. J. HANTOVER: This says that this resolution was introduced by the Montgomery County Medical Society. Well, I am from that Society and I would like to inform you that this resolution was not introduced by the Montgomery County Medical Society. This is in error.

DR. EUGENE JOHNSON: I would like to say that I submitted the resolution from Clark County.

(At this point a standing count relative to the motion was taken.)

PRESIDENT HESSELTINE: The count indicates that 83 were in favor of the motion and 68 against. The motion, as amended, is therefore declared to be carried.)

DR. ALLISON: I now move the adoption of the report of this committee, as a whole, as amended. (Seconded.)

DR. C. J. JANNINGS: I believe it would be proper, in considering the report as a whole, to look over what we accepted in connection with the review of the report of the Committee on School Health. I believe that there we voted to go on record as being opposed to football in the freshman year of high school.

If you will refer to the manual relative to this report, recommendation No. 1, it states that schools should not include body contact sports, particularly types of football and boxing, for children of school age through the ninth grade.

The way I interpret this, therefore, is that we are going on record as opposing football in the freshman year in high school.

The Committee on School Health recommends that it is not thought to be harmful for children to participate in body contact sports. Therefore, the way I get this, if you start with a baby and the baby falls and bounces, he doesn't ordinarily hurt himself. However, as the child grows older and participates in different sports, if these sports are properly supervised and if proper protective equipment is provided, that this then is a healthy thing.

However, the main point that I wish to call to your attention is the fact that throughout the State of Illinois it is part of the High School Athletic Program for freshman and sophomore football teams to be in competition. Therefore, I would be strongly opposed to this particular section. I would make a motion that we refer this matter back to the Committee on School Health, this Section 7, and for it to be resubmitted at our next meeting. (Seconded)

DR. FULLERTON: There has been a lot of evidence presented in our Committee on School Health and before the 1960 White House Conference on Children and Youth.

This is one of the recommendations that came out of that White House Conference from the Illinois Committee. It was put in there mainly because of the efforts of the members of your committee.

There is a lot of clinical evidence in support of those recommendations. Dr. Reichert is one of the authorities on it and even some of the educators have gone along with the support of these recommendations.

For example, there is one of the professors down at the University of Illinois, in the Department of Physical Education, who has written a recent article for publication in an educational magazine entitled "Football is not for Pee-wees". This was the title of his paper and he then went on to explain why.

Therefore, we are not making these recommendations without clinical evidence and I would like to indicate that I oppose the motion.

DR. R. R. MUSTELL: During the ten years that I was examining with the CYO here and also the Golden Gloves, it was necessary, at least in the CYO, to discontinue a certain amount of the boxers who had been fighting for more than a year or two. If we look at the papers and follow the intercollegiate boxing program, you will find, one by one, that the colleges are discontinuing this service.

If doctors as a whole consider preventive medicine at all, then I do not understand how they could endorse at least the boxing program.

DR. E. T. McENERY: I would like to support the idea that this be referred back to the Reference Committee for restatement.

I would also like to make these comments — that I happened to be a representative of the Academy of Pediatrics to the White House Conference in Washington, and this was the recommendation that they made there and many, many organizations were represented in the discussion and, as a result, they came up with the recommendation as given in the Handbook.

In addition to this, I was also your state representative at the last meeting in Washington on physical fitness and this was discussed. Further, a lot of pictures were shown. Many men discussed these questions and indicated there were a lot of injuries sustained in boxing and in football by these young boys in the ninth grade.

As far as I am concerned, I feel that they are still children, they are not youths — that they are not picked for this contact sport and, therefore, I again would suggest that we refer it back to the Reference Committee for reconsideration.

(A standing count was then taken.)

PRESIDENT HESSELTINE: The vote is 94 for referral and 48 against. Therefore, it will be referred back to the Reference Committee.

Reference Committee on Council Committees
Dr. Charles Allison, Chairman

This pertains to Section No. 7 of the full report as submitted on May 16 and recommended for reconsideration.

We move that the House of Delegates ratify the approval given the report submitted Tuesday evening except that part pertaining to the report of the Committee on School Health which was sent back to the Reference Committee for reconsideration. (Adopted)

With reference to Section 7 of the report referred back to the committee, I would like to advise that this was reconsidered in open hearing on Wednesday, May 17, 1961. Twelve witnesses appeared, five pieces of printed material, two personal communications, one resolution from the Illinois Chapter of the American Academy of Pediatrics (now in session) and a personal resolution, were received.

Discussion by those who testified "approved in principle" the report of the committee as submitted Tuesday evening.

The printed material submitted all endorsed the action of the Committee on School Health's report as it pertained to the report and recommendations of the White House Conference on Children and Youth.

The delegate who initiated the recommittment of the section, in a personal communication, said: "Please be assured that the proposal has my wholehearted support", and proposed a resolution which also endorsed the principles behind the report.

The objectors, in marked minority, agreed with the check list contained in the pamphlet "Safeguarding the Health of the High School Athlete" — a joint statement of the Committee on Injury in Sports of the AMA and the National Federation of State High School Athletic Associations.

Therefore the committee moves that the House reaffirm its approval of Section 7 of the report of Committee No. 4. (Adopted)

Special Reference Committee to Consider Resolutions Nos. 1961-2, 1961-29 and 1961-42
Dr. W. O. Ackley, Chairman

RESOLUTIONS 1961-2, 1961-29 and 1961-42 deal with

some phase of the problems which confront the self-employed physician who wishes to make provision for an income tax-deferred pension or retirement plan.

The essence of the respective resolutions is as follows:

No. 1961-2. Proposes that the Council appoint a committee to study the matter and report to the next meeting of the House of Delegates;

No. 1961-29. Proposes efforts to obtain enabling legislation from the current Illinois General Assembly; and

No. 1961-42. Proposes to amend the Medical Service Plans Enabling Act to authorize Blue Shield corporations to act as custodians of funds otherwise payable as fees to participating physicians.

In the course of its discussion, it became apparent to the committee that numerous legal and practical problems are involved, and that it would be unwise for the House of Delegates to attempt to arrive at any detailed decisions as to how the objectives might best be pursued. Among these problems are the probable necessity of obtaining a ruling on any such proposal from the Internal Revenue Service, the fact that the Illinois General Assembly will adjourn on June 30 next, and the need for ascertaining the attitude of the Blue Shield Plans toward any such undertaking on their parts. For that reason, as a substitute to Resolutions 2, 29 and 42, your committee recommends the adoption of the following resolution:

WHEREAS, the establishment of tax-deferred retirement programs for members of the Illinois State Medical Society is a matter of proper concern to the Society, and

WHEREAS, wisdom requires that the complexities of establishing such programs be carefully explored before decisions are made, now

THEREFORE BE IT RESOLVED: That the Council of the Illinois State Medical Society be hereby directed to appoint or designate a commitee to be charged with the responsibility of investigating the several problems and the complexities which present themselves, and to proceed to prepare recommendations for the approval of the Council with respect to the establishment of a tax-deferred pension or retirement program for members of the Society; and

BE IT FURTHER RESOLVED: That the results of such study, prior to any implementation, be reported by the Council to the House of Delegates at its next meeting, or by mail at an earlier date if this should prove feasible. (Adopted)

THIRD SESSION
Thursday, May 18, 1961

The third meeting of the House of Delegates of the Illinois State Medical Society was convened at nine-fifteen o'clock a.m., President Hesseltine, presiding.

PRESIDENT HESSELTINE: I will now call upon Dr. Coye C. Mason, Director and Chairman of Scientific Exhibits, to announce the awards pertaining to the scientific exhibits.

DR. MASON: I would like to make one note about the exhibits this year.

I have never felt it the prerogative of the chairman of exhibits to comment on exhibits. However, there was one exhibit in the hall that most of us felt merited a gold medal. It was that exhibit which many of you spent considerable time reviewing, on "Correlative Pathology", which was put together by Dr. Grant Johnson, pathologist for the Memorial Hospital in Springfield. This, to us, was an outstanding exhibit. It is one which we want Dr. Johnson to present every year because we feel it has great value in teaching and I hope that those of you who know Dr. Johnson will make every effort to encourage him to come back and repeat this next year and in the years to come.

At this point I wish to present the complete Scientific Awards.

I. FOR ORIGINAL CONTRIBUTIONS

THE GOLD MEDAL: Booth 22
"Significance of Vascular Injury on Pancreatitis; New Concepts of Pathogenesis."
Exhibitors: Marion C. Anderson, John J. Bergan and Phillip Wright
Institution: Northwestern University Medical School

THE SILVER MEDAL: Booth 20
"Intravenous Abdominal Arteriography."
Exhibitors: Howard C. Burkhead, George C. Sutton, William T. Meszaros, John B. Graham, Myles P. Cunningham and Brown Brooks.
Institution: Evanston Hospital, Cook County Hospital and Northwestern University Medical School.

BRONZE MEDALS:

1. Booth 27.
"Autogenous Oxygenation and Hypothermia for Heart Surgery."
Exhibitors: F. John Lewis and Christopher T. Drake.
Institution: Northwestern University Medical School.
2. Booth 8
"The Measurement of Pain, a New Approach to an Old Problem."
Exhibitor: Eric C. Kast
Institution: Chicago Medical School
3. Booth 24
"Lesions Presenting in Right Cardiophrenic Angle."
Exhibitors: Hildegarde Schorsch, Edward A. Pisczek and Ki Eun Chung
Institutions: Cook County Hospital, Stritch School of Medicine, Loyola University, The Suburban Cook County Tuberculosis Sanitarium District.

II. FOR EDUCATIONAL VALUE

THE GOLD MEDAL: Booth 2
"Visualization of Basic Principles of Human Reproduction."
Exhibitors: Frederick H. Falls and Charlotte Holt
Institutions: State of Illinois, Department of Public Health, Springfield, Illinois

THE SILVER MEDAL: Booth 17
"Tuberculosis" X-Ray Clinical Case Presenation."
Exhibitors: Karl H. Pfuetze, George E. Turner, Meyer Lichtenstein and Edward A. Piszczek
Institutions: Chicago State Tuberculosis Sanitarium, Cook County Hospital Institutions, Municipal Tuberculosis Sanitarium and Suburban Cook County Tuberculosis Sanitarium District.

BRONZE MEDALS:

1. Booth 18.
"Cancer — Prevention of Dissemination."
Exhibitors: William J. Grove, Warren H. Cole and Associates.
Institutions: University of Illinois College of Medicine, Department of Surgery.
2. Booth 19
"Selective Bronchography in the Differential Diagnosis of Lung Disease."
Exhibitors: Joseph J. Litschgi, George W. Holmes, and Gisela Albrecht
Institution: Cook County Hospital, Chicago.
3. Booth 21
"Transfusions: Whole Blood or its Fractions?"
Exhibitors: William Best, H. A. Grimm and Coye C. Mason, Chicago.

Mr. Chairman, this report is submitted by your Committee on Scientific Exhibits. (Adopted)

(The next order of business was election of officers, councilors and committees.)

Officers

(Unanimously elected)

President Elect: Dr. George F. Lull
First Vice President: Dr. William Whiting, Anna
Second Vice President: Dr. Eugene E. McEnery, Chicago
Secretary-Treasurer: Dr. Jacob E. Reisch, Springfield
Presiding Officer: Dr. Walter Bornemeier, Chicago
Ass't. Presiding Officer: Dr. Harlan English, Danville

Councilors

Third District: Dr. William E. Adams and Dr. John Lester Reichert
Fourth District: Dr. Fred C. Endres
Fifth District: Dr. Jacob E. Reisch
Seventh District: Dr. Arthur Goodyear
Eighth District: Dr. Harlan English

Delegates to AMA

Two Year Terms — effective Jan. 1, 1962

Dr. H. Kenneth Scatliff, Dr. Walter C. Bornemeier, Dr. Frank H. Fowler, Dr. Arthur F. Goodyear and Dr. Harlan English.

Dr. E. W. Cannady was elected to fill the vacancy of Dr. Joseph T. O'Neill.

Alternate Delegates to AMA

Two Year Terms — Effective Jan. 1, 1962

Dr. Eugene McEnery, Dr. George C. Turner and Dr. Edward A. Piszczek.

Dr. Newton DuPuy was elected alternate for Dr. Goodyear; Dr. Jacob E. Reisch alternate for Dr. English; Dr. Carl Clark alternate for Dr. Cannady.

Standing Committees

Grievance Committee: Dr. Arkell M. Vaughn, Dr. Willis Lewis (Three year terms)
Medcial Benevolence: Dr. Keith L. Frankhauser (Three year term)
Medical Education and Hospitals: Dr. Kenneth C. Johnston, Dr. Ward Eastman, Dr. George O'Brien (One year term)
Medico Legal: Dr. Leo P. A. Sweeney, Dr. F. E. Bihss (three year term)
Medical Testimony: Dr. Joseph F. O'Malley, Dr. L. F. Rockey (Four year term) Dr. Allison Burdick (replacing Dr. J. H. Shivers to 1962)
Pre-payment Plans & Organizations: Dr. Harry Mantz (Three year term)

DR. E. A. PISZCZEK: In consultation with the Finance Committee, the Council advises that dues for 1962 remain the same. (Adopted)

DR. GOODYEAR: With regard to proposed changes in the Constitution and Bylaws, the following revision in the constitution and bylaws is hereby presented for your consideration:

Article IX, Section 2, "Officers", be revised to read as follows:

"Section 2. The President-Elect, Vice Presidents, Presiding Officer and Alternate Presiding Officer shall be elected annually by the House of Delegates to serve for a term of one year. The Councilors shall be elected by the House of Delegates to serve for three years. All Officers shall serve until their successors are elected and installed. The Secretary-Treasurer shall be elected from the Council for a term of one year at the first meeting of the Council following the Annual Meeting of the House of Delegates. The Presiding Officer and Alternate Presiding Officer shall not be elected for more than two consecutive terms of their respective offices. They shall be elected from among the members of this House of Delegates."

I move that this be referred to the Committee on Constitution and Bylaws for study and report at the next Annual Meeting of the House of Delegates. (Adopted)

DR. PISZCZEK: For the information of the House of Delegates, I would like to inform you that the Executive Committee is going to recommend to the Council that we codify all of the actions of the House of Delegates over a period of time and that these be presented to you next year for your action and then, at any time that any member of the House of Delegates desires to change any of the previous actions of the Council, which will be in pamphlet form, that the delegates to the convention can do so by proper resolution, either as individuals or from the counties.

We think that there will be basic information for you on the policies enumerated by the House of Delegates in our Annual Meetings and will give to you the recorded policies of the State Medical Society.

PRESIDENT HESSELTINE: This is one time when your President (and I am sure my predecessors felt the same way) desires to tell you of his appreciation and grateful thanks for all of the cooperation and support that he has received throughout the year, not for himself, because he is merely the figurehead of your Society, but for the good and welfare of the Society.

The cooperation has been excellent and the committees have all shown this cooperation.

It is indeed a pleasure to report to you the unity that prevailed throughout our State Society. We are a democratic organization and we have kept it sound. I have great confidence in your progress ahead.

It has been wonderful to have been your President. Mrs. Hesseltine and I are most grateful to you and indebted to you for the honor which is exceptional and, unfortunately, can only get to a few people. However, once it is given, people usually become selfish and are unwilling to give it up.

We have been treated so nicely that at times we wondered whether or not we were dreaming.

I would like to make a comment or two about our staff personnel.

They are efficient, they are cooperative and there is a remarkable esprit de corps which prevails in our headquarters office. I am acquainted with a fair number of State Medical Society personnel and staffs. I am not willing to trade one of their men for any of our group. Of course, this is no reflection on the others, but it is a compliment, to you, to your judgment and the way you have set it up. It is also a compliment to them. However, they still have many things to do and accomplish and so they should not get overconfident about our confidence in them.

I have grown to understand them and know them and for the first time I am telling them that I personally like them. I have never mentioned that before. I have thought it out of character. However, since I do have a few moments before I become a private citizen, I feel that maybe I am entitled to express that.

You have been a wonderful audience. Your Reference Committees and you have been most cooperative. There are so many of you I would like to think that it gets to the place where everyone is a chief and there are no Indians. Of course, I think in our organization it is wonderful that we are all chiefs. Therefore, if I have overlooked any one, I do want to tell you that you have all been included.

When I was inducted into office last year, my predecessor, Dr. O'Neill had it in good order, without tarnish or stain. One can almost hear the echo of his tactful use of wit and his humor and democratic philosophy.

My contributions, if any, are most likely to be noted in an effort to perpetuate the industry and integrity and the investigations of our Society and of your Society.

I want to tell you again it has been wonderful. I will always cherish your respect and tribute to me and I want to thank you on behalf of Mrs. Hesseltine and myself.

Now then, we come to that very rich moment in which my successor is to come into office.

Dr. Hamilton is a man who has probably given as much effort or more than any man and probably equal to two or three in the state so far as his brain power and his blood for organized medicine is concerned. He is thor-

oughly dedicated to organized medicine. He will serve you well because there is only one hobby he has and that is organized medicine.

I will not give you a resume of all of his interests in the past because that is available to you. However, if the gentlemen whom I have appointed will now escort him to the podium, I will have the pleasure of installing him as President.

(The delegates applauded as Dr. Hamilton was escorted to the rostrum.)

PRESIDENT HESSELTINE: Dr. Hamilton, there are two parts to this ceremony. One of them is the presentation of the Oldfield Medallion, which we are most happy to do. You know, I never suspected in my life, until last year, that I would ever do anything ahead of Dr. Hamilton. Well, the presentation of the Medallion is one thing I am doing now.

Also, symbolic of your office, Dr. Hamilton, it is with real pride that I present to you this gavel.

(See July, 1961, IMJ for Dr. Hamilton's address.)

At one o'clock p.m., the session of the House of Delegates of the Illinois State Medical Society was adjourned sine die.)

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A new age

I think my message could be compressed into a single paragraph growing out of my singular experience as a newspaperman trying to pinpoint what is truly the national interest in this struggle.

First, the challenge of assuring medical, hospital, and nursing home care for elderly citizens has now been accepted by all segments of society. The problem itself could be reduced by reversing trends toward mandatory retirement of worthy and capable persons at the chronological ages of 60 to 65.

But assuredly, if the insurance industry or other nongovernmental sources are to dispatch the problem, they must be more aggressive in the future than they have been in the past. And in any event, they should re-examine their philosophical orientation to the real problems of a changing world, separating their decisions from old concepts, old standards and old assumptions that may not meet the challenges of a new age. *Robert W. Lucas. The Challenge of a New Age. Health Insurance Viewpoints. June* 1961.

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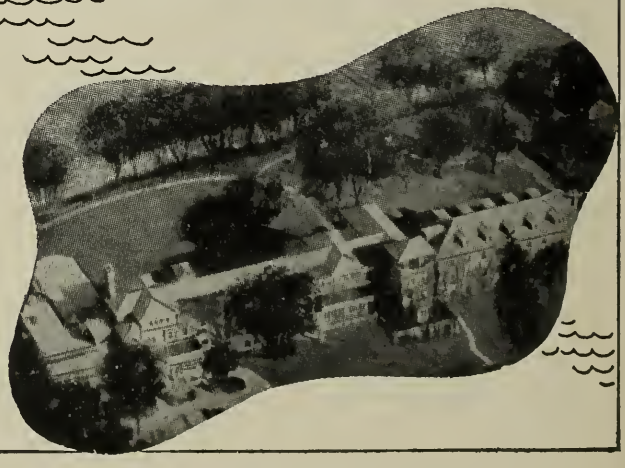
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The press errs

Is your doctor out-of-date? The other week several newspapers came out in their frank outspoken way with articles on this subject. How, they asked, can the overworked doctor, on the verge of physical and mental collapse, possibly keep abreast of all the new trends?

"Between midnight and dawn," one of them suggested, "he awaits the peremptory ring of the emergency call from a patient." For myself, I sleep awaiting nothing; and, if the phone does ring, I am incredulous that anybody should not be able to wait until morning. A farmer once woke me out of a deep sleep to ask me to leave out some tablets for his wife. It was quite dark outside. "Surely you could have waited until the morning, and not wakened me up in the middle of the night," I said testily. "But doctor," the farmer said, "it has gone half-past six."

Another suggestion was that the poor doctor "has hardly even time to sign the death certificate before rushing to the next patient." On those rare occasions when I have a death certificate to sign, I get up early and make sure that I am not rushing anywhere. I sit back and rough it out in my mind, step by step, letting my imagination have full rein. Then, cause and effect in due sequence, with quiet conviction—for who can say I am wrong?—I slowly and clearly write it all down. For the interval between onset and death I put down, say, eight years with all the sureness of one who was crawling down the coronary arteries, torch in hand, and witnessed the very first atheromatous deposit.

Still, it's nice to think that the Press realise that the doctor *has* difficulties—even though they haven't hit on the ones that worry him most. *In England Now. Lancet. May 13, 1961.*

Quacks for quacks

The philosophy of most cancer charlatans may be summed up by quoting a slogan which Harry Hoxsey keeps on his desk—"The world is made up of two kinds of people, dem dat takes and dem dat gets took." We must impress on our patients and the public that these so-called "cancer cures" are for the birds and that quacks are for ducks. *Joseph L. Kovarik, M.D. Cancer Quackery. Rocky Mountain M. J. May 1961.*



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1. Coolidge, C. W.; Glisson, C. S., Jr., and Smith, A. A.: J. M. A. Georgia 48:167 (Apr.) 1959. 2. Ensey, J. E.: Am. J. Obst. & Gynec. 77:155 (Jan.) 1959. 3. Frech, H. C., and Lanier, L. R., Jr.: J. M. A. Georgia 47:498 (Oct.) 1958.

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Approved Psychiatric Residency for General Practitioners or Others: First year appointment beginning July 1, 1962, in well integrated psychiatric training program associated with State University of Iowa Psychiatric Department and the University of Nebraska College of Medicine. Requirements: Must be a citizen of United States or have expressed an intention of becoming one; have completed internship four years prior to July 1, 1962, and have been in practice during that period. Time served in Armed Forces or residency training in some other specialty acceptable. Preference given to applicants under forty-five years of age. Annual stipend $12,000. Applications should be made immediately. Write W. C. Brinegar, M.D., Superintendent, Mental Health Institute, Cherokee, Iowa.

THE CHICAGO MEDICAL SCHOOL RESIDENCY IN PSYCHIATRY. The psychiatric residency and fellowship program offered by the Chicago Medical School, approved by the American Medical Association and leading to certification by the American Psychiatric Association, has some openings for the academic year 1962-63.

The program, greatly expanded in 1959, offers unlimited possibilities for well qualified persons interested in the multidisciplinary field of psychiatry. Facilities available: (1) Mount Sinai Hospital, Chicago, a 388-bed general hospital with an inpatient neuropsychiatric service of 28 beds and with adult and child psychiatry and neurology clinics; (2) Illinois State Psychiatric Institute; (3) V.A. West Side Hospital; (4) selected social agencies and court clinics.

The training program includes broad experience in dynamic psychiatry and neurology with emphasis on psychosomatic medicine and psychophysiological correlations, the development of skills in psychotherapy, physiological and pharmacological therapies, psychosocial intervention, preventive and forensic aspects and a comprehensive psychiatric approach to emotionally and physically sick persons.

The residency is viewed as a learning rather than a service situation, and full attention is paid to the development of the trainee's broad cultural knowledge, as well as his special potentialities.

The program, balanced between didactic and practical training, is supervised by qualified psychiatrists and neurologists — faculty members of The Chicago Medical School and attending staff of the Mount Sinai Hospital and of affiliated hospitals. Extensive facilities for both clinical and basic research are provided. Stipends

(1) The hospital offers to residents $2,700 in the first year, augmented by $300 for each subsequent year, in addition to various benefits, such as partial maintenance, free medical care, vacation and sick leave.

(2) U.S. Public Health Service fellowships (non-taxable) are available, providing $2,400 the first year and $600 for each additional year of training to a total of 3 years.

(3) A special U.S. Public Health Service fellowship providing up to $12,000 a year is available for (licensed) general practitioners wishing to specialize in psychiatry.

Address inquiries to: Dr. Harry H. Garner, Professor and Chairman, Department of Psychiatry and Neurology, The Chicago Medical School, 710 South Wolcott Avenue, Chicago 12, Illinois.

Before Titov

All is not well with the Communist bloc. The Communists have made very few gains in terms of being able to tie down real gains and achievements.

Today Asia is not more communistic. The countries of Asia that have not been taken over openly by Red arms are developing a viable economy and institutions of freedom. They not only survive, but they grow in strength.

So I say to my fellow Americans: "Do not feel as if all the problems are ours and that all the difficulties fall upon us. There are difficulties in the Communist camp."

I believe that what this Nation needs above all today is a sense of confidence. What this country needs and what our allies need is a reappraisal of our genuine strength. We represent 75 per cent of the wealth of the world. We represent the greatest industrial capacity that the world has ever known. If we add the industrial capacity of United States, Canada, Western Europe, and Japan, I submit that the world has never seen anything like it, and that the Communist empire fades into insignificance. We are stronger in science and technology and stronger in per capita income and in resources and in wealth and in industrial production. We can be stronger in every way if we have the will and the determination. *Senator Hubert Humphrey. U.S. Disarmament Agency for World Peace and Security. Congressional Record. Proceedings and Debates of the* 87th *Congress, First Session. June* 29, 1961.

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Address Communications

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Abstract of Council Actions

Meeting of Sept. 16, 1961

SPECIAL MEETING OF HOUSE OF DELEGATES, OCTOBER 28-29

The Council voted to call a special meeting of the House of Delegates, October 28-29, to consider regulations of the Illinois Public Aid Commission for the administration of the (Kerr-Mills) Aid to the Medically Indigent Aged program in Illinois.

The meeting will convene in the Sheraton-Chicago, at 7 p.m. Saturday, Oct. 28, and will be devoted to presentation of a report by an Ad Hoc Committee which has been conferring with the IPAC. The reference committee will meet that evening, and report back to the House Sunday morning. The action of the House will conclude the session.

Dr. Edwin S. Hamilton, president, explained that the Executive Committee was of the opinion that the matter involved policy of sufficient importance for submission to the House, and so recommended. The Council concurred.

Details of the question to be considered have been mailed to all delegates, alternate delegates and officers of county medical societies.

COUNCIL CONCURS IN RECOMMENDATIONS ON POLIO VACCINES

Dr. John Lester Reichert, chairman of the Committee on Child Health, reported that a Subcommittee on Poliomyelitis made the following recommendations:

(1) A mass preventive program using three types of attenuated virus orally.

(2) The use of oral vaccine when all three types are available in adequate amounts, but not before.

(3) Organization of the program under medical leadership.

(4) Immediate planning, although type III may not be available for several weeks, and type II for several months, because: (a) it takes two or three months to get the program organized; (b) it requires a co-operative plan with local official and voluntary organizations; (c) it requires a decision as to what phases of administration should be done in an M.D.'s office.

(5) Vigorous use of Salk vaccine to and through the mass program of attenuated virus because: (a) Salk vaccine gives immunity to all types of poliomyelitis, and (b) increased neurotropism of attenuated virus could theoretically produce clinical poliomyelitis in the totally unprotected.

AMA COMPLIMENTS ISMS ON EFFORTS AGAINST KING BILL

A letter from Dr. F. J. L. Blasingame, executive vice president of the AMA, complimented the ISMS for its efforts in generating opposition to the King-Anderson Bill (H.R. 4222) in Congress. The letter said that the testimony presented by Dr. Edward W. Cannady of East St. Louis, chairman of the Committee on Aging, and Dr. H. Close Hesseltine of Chicago, immediate past president, "was most informative and impressive to the members of the (House Ways and Means) Committee."

Dr. Blasingame also commended the ISMS for encouraging county medical societies, such as DuPage, Vermilion, and Lake, to request time to present testimony. The testimony of the Illinois Public Health Association and the Illinois Chamber of Commerce was most helpful, and the ISMS was complimented for securing support of this type. The "Pen a Line For Freedom" campaign encouraged physicians all over the state to write letters to their congressmen concerning these hearings, the letter said.

BROADENING OF HEART SCREENING PROGRAM AT THIS TIME OPPOSED

Dr. John Lester Reichert of Chicago, chairman of a Special Cardiac Screening Committee, reported on a heart screening program in which the Chicago Heart Association has taken the lead, with other public agencies participating. By means of a special tape recording of heart sounds, it has been possible to screen thousands of school children for heart disease in a short time and with a high degree of accuracy.

Dr. Reichert said that while details remain to be worked out, the program shows great promise. However, some interests have proposed to Gov. Kerner that the program be expanded to a state-wide basis.

The committee, composed of outstanding cardiologists closely associated with the Chicago program, was of the opinion that there should be no expansion at this time. It pointed out that the Chicago study had brought to light problems which must be solved while the project is still a limited pilot program.

Among the unsolved problems are the need to define in greater detail the scientific objectives, a further spelling out of instrumentation, the setting up of more accurate state-wide and national standards, further refinements in technical methods, and the recruitment of enough qualified cardiologists to interpret the enormous number of recordings in a state-wide project.

The Council agreed with the committee that the program should not be broadened beyond Chicago at this time.

PROGRESS IN IMPARTIAL MEDICAL TESTIMONY PLAN IN STATE COURTS

A progress report on the introduction of impartial medical testimony into the state courts was made by Dr. Samuel A. Levinson of Chicago, chairman of the Committee on Impartial Medical Testimony. The program went into effect on September 5, and a plan of implementation has been submitted to the Illinois Supreme Court.

The Illinois State Medical Society has made a contribution of $5,000 toward the administration of the program, but additional funds are needed. Efforts are being made to obtain grants from foundations.

Representatives of the ISMS are to meet with representatives of the Illinois State Bar Association, to discuss the program. The situation in the state courts in Cook County is especially acute with a backlog of more than 69,021 cases, the largest in the nation. The impartial medical testimony plan is expected to help break the jam. Organized medicine, therefore, is rendering a distinct public service.

POSTGRADUATE COMMITTEE READY TO SUPPLY HIGH CALIBER SPEAKERS

Dr. Noel G. Shaw of Evanston, chairman of the Committee on Postgraduate Medical Education and Scientific Service reported that the committee is prepared to supply teams of three or four speakers for postgraduate conferences downstate, and individual speakers for county medical society meetings.

COUNCILORS MEET WITH COMMITTEE CHAIRMEN

A workshop for ISMS committee chairmen was held Sunday morning, September 17, at the Drake Hotel, Chicago. Following opening remarks by President Edwin S. Hamilton and Dr. Edward A. Piszczek, Chairman of the Council, Executive Administrator Robert L. Richards discussed administrative problems such as budgeting, expense accounts, annual reports and the general responsibilities of committees.

The committee chairmen then adjourned to five discussion groups, each presided over by a member of the council and assisted by three councilor-discussion leaders and the staff director assigned to the particular group of committees. Spirited discussion ensued as the committee chairmen told of their problems and plans. Each discussion group was "reported" by a staff representative from the AMA, each of whom delivered a brief summary at the session-closing luncheon. Leo E. Brown, Executive Assistant of the AMA, concluded the workshop with an address in which he lauded the progress made by ISMS since the administrative reorganization last year.

Volume 120, No. 4 October, 1961

The ILLINOIS Medical Journal

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Published monthly by the Illinois State Medical Society, 360 N. Michigan Avenue, Chicago 1, Ill. Subscription $5.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, and Mexico. $7.00 per year for all foreign countries included in the postal union. Canada, $5.50. Single current copies 75 cents.

Second class postage paid at Chicago, Illinois. POSTMASTER: Send notices on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago 1, Ill.

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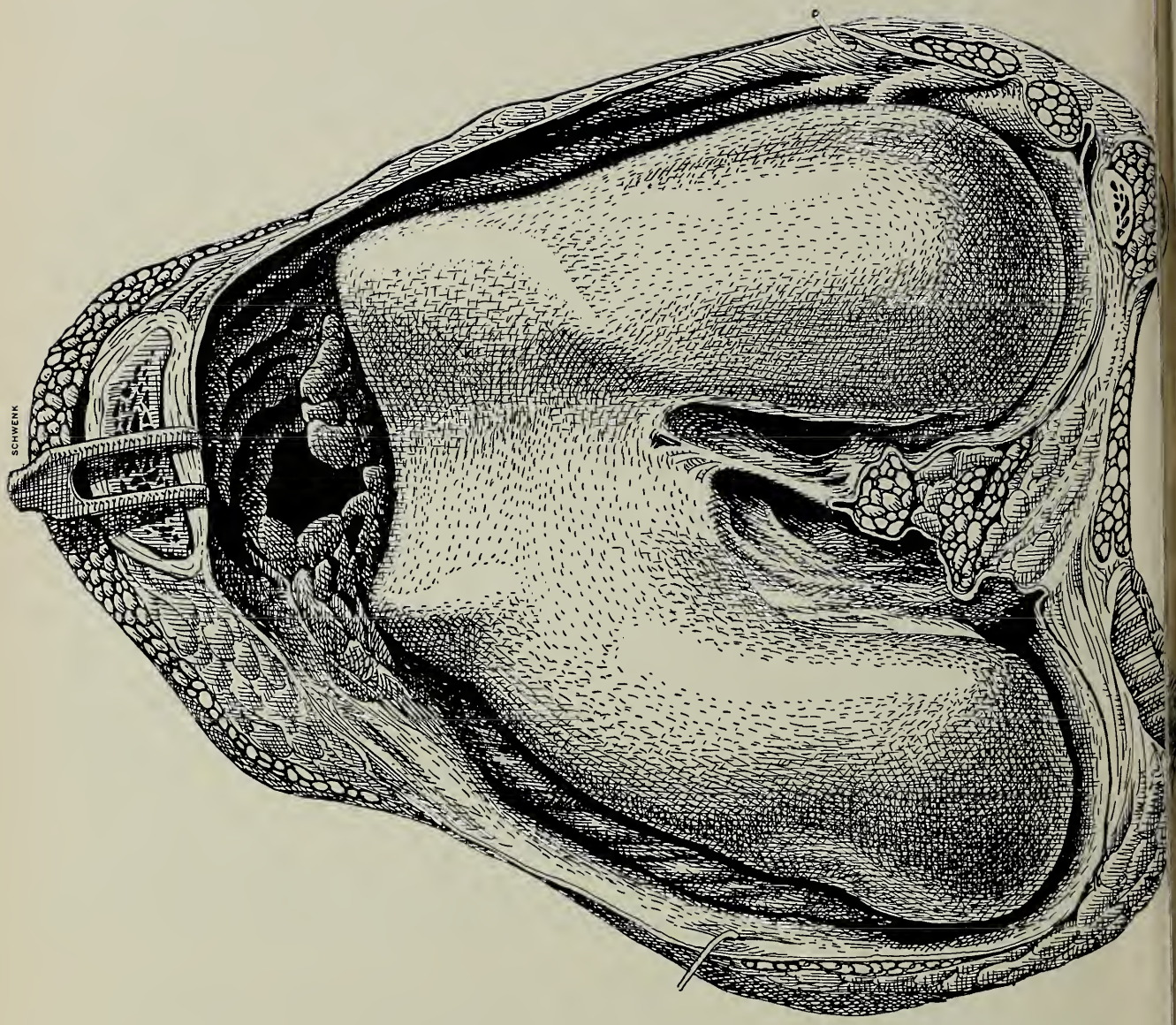
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because patients are more than arthritic joints...

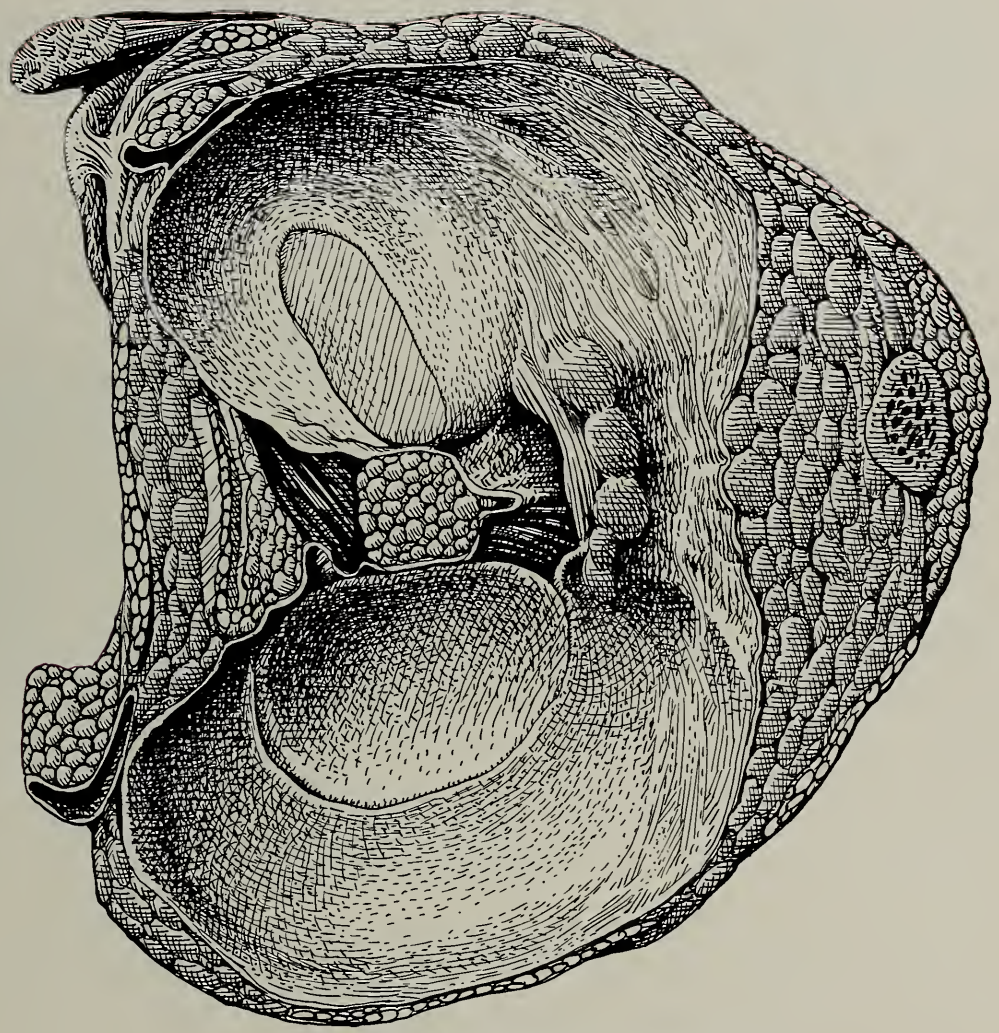
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ISMS

Announcements

Heart Association Annual Session

Six sessions on clinical cardiology will be included in the annual scientific sessions of the American Heart Association October 20-22 at the Americana Hotel, Bal Harbour, in Miami Beach. A panel or symposium including related investigative work will be presented at each clinical session.

In addition, a total of 18 other scientific sessions will be held concurrently during the three-day program.

A tentative outline of the program follows:

FRIDAY: The sessions on clinical cardiology include an opening address by Dr. Oglesby Paul, AHA president; the Conner Memorial Lecture, by Dr. Clark H. Millikan, professor of neurology, Mayo Clinic; symposia on "Contribution of Phonocardiography to Auscultation," and on "Coronary Arteriography"; a lecture on "Biplane Angiography" by Dr. Herbert L. Abrams, Stanford Medical Center. Concurrent sessions are scheduled on arteriosclerosis, on biophysical methods in the study of circulation, and on high blood pressure research. A program for nurses is also scheduled concerning cardiovascular research as it relates to care of the cardiac patient.

SATURDAY: The clinical sessions will include a panel on "Ventricular Arrhythmias"; a lecture on "Closed Chest Cardiac Resuscitation" by Dr. James R. Jude, Johns Hopkins Hospital; the Brown Memorial Lecture on "Physiology of the Peripheral Circulation" by Dr. Robert W. Wilkins, professor of medicine, Boston University School of Medicine; and a symposium on "Renal Failure." Simultaneous scientific sessions will be held in the fields of basic science, cardiovascular surgery, and on "Compensable Heart Disease, Strain and Trauma."

Scheduled for Saturday evening are Cardiac Conferences, which will give physicians an opportunity to participate in small group discussions.

SUNDAY: Subjects for the clinical sessions include a symposium on "The Role of Hormones in Heart Failure"; panels on "Ventricular Hypertrophy and Bundle Branch Block" and "Newer Electrocardiographic Lead Systems"; and a lecture on "ECG Clues Suggesting Myocardial Infarction" by Dr. Junior A. Abildskov, assistant professor of medicine, State University of New York College of Medicine. Concurrent sessions will be held on rheumatic fever and congenital heart disease and on cardiovascular surgery. Cardiovascular films, with introduction and commentary by the author or other authority on the subject of each film, will be shown throughout Sunday.

Scientific and industrial exhibits will be on display.

Registration forms, which include applications for hotel reservations, are available from the American Heart Association, 44 E. 23rd St., New York 10.

The association's Council on Arteriosclerosis will meet preceding the Scientific Sessions.

All interested physicians, whether or not they are members of the Council, are invited.

Symposium on Speech Handicaps

Neuromuscular, brain, and therapy problems relating to speech handicaps for the cerebral palsy patient will be discussed in a symposium at the Sherman Hotel, Chicago, November 7.

The session, planned by the program committee of the American Speech and Hearing Association, will be sponsored by the National Society for Crippled Children and Adults.

Medical authorities participating are Hans Zellweger, professor of pediatrics, State University of Iowa; Cyril B. Courville, Cajal Labo-

(continued on page 10)

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ratory of Neuropathology, Los Angeles County Hospital; Meyer A. Perlstein, professor of pediatrics, Cook County Postgraduate School of Medicine, and associate professor of pediatrics, Northwestern University Medical School; and Raymond R. Rembolt, director, University Hospital School for Severely Handicapped Children, and professor of pediatrics, State University of Iowa. In addition, Eugene T. McDonald, Ph.D., director of the speech and hearing clinic, Pennsylvania University, State College, will participate.

James C. Hardy, Ph.D., University Hospital School, State University of Iowa, will be chairman.

Milwaukee Meeting on Psychiatry

The American Psychiatric Association plans its Milwaukee Divisional Meeting for November 16-18 at the Hotel Schroeder and invites all physicians and personnel in related fields.

Two Chicago physicians, Jules H. Masserman and Eugene I. Falstein, will be moderators of panel discussions; and another, Melvin Sapson, will be a discussant. Panel subjects include Ethics and Psychiatry, The Future of the Mental Hospital, Present Status of Drugs and Psychiatry, and Psychiatry.

Scheduled also is a symposium on "Impulses."

Registration is $5; for additional information write the Association at 756 N. Milwaukee St., Milwaukee 2.

PG Course in Mental Health

The Illinois Academy of General Practice's *Mental Health Course* for 1961-62 will consist of seminar sessions on "Psychodynamics and Office Management of Emotional Disorders." The course, sponsored by the Commission on Postgraduate Education and the Mental Health Committee, will be given at two locations. One will be the Lutheran General Hospital in Park Ridge on the first and third Wednesday of each month from November, 1961, through March, 1962, 10:30 a.m. to noon; the moderator will be Dr. Samuel Liebman, clinical assistant professor of psychiatry at the University of Illinois College of Medicine. The other will be the Edgewater Hospital, Chicago, on the first and third Tuesday of each month, at the same hours; the moderator will be Dr. Howard Zeitlin, head of the department of psychiatry at the hospital.

Members may claim 15 hours of Category I credit for the course. The matriculation fee is $50; registration is limited. Contact the Academy at 14 E. Jackson Blvd., Chicago 4, for more information.

Chicago Diabetes Association Plans Yearly Symposium

The Chicago Diabetes Association will conduct its annual Symposium on Diabetes at the Offield Auditorium, Passavant Memorial Hospital, Friday, November 10, at 9 p.m. Physician speakers include George F. Cahill, Jr., Peter Bent Brigham Hospital, Boston; Paul E. Lacy, Washington University School of Medicine, St. Louis; Geza de Takats, Marvin Cornblath, and Theodore B. Schwartz, University of Illinois College of Medicine; Arthur R. Colwell and Ralph E. Dolkart, Northwestern University Medical School; Albert Dorfman, University of Chicago Medical School; and William C. Shoemaker and Piero P. Foa, Chicago Medical School.

There will be a round-table discussion led by some of the speakers.

Registration is free for members of the association, the American Diabetes Association, and medical students and resident house staff members; for nonmembers the fee is $25. Members of the Academy of General Practice may claim hour for hour credit in Category II.

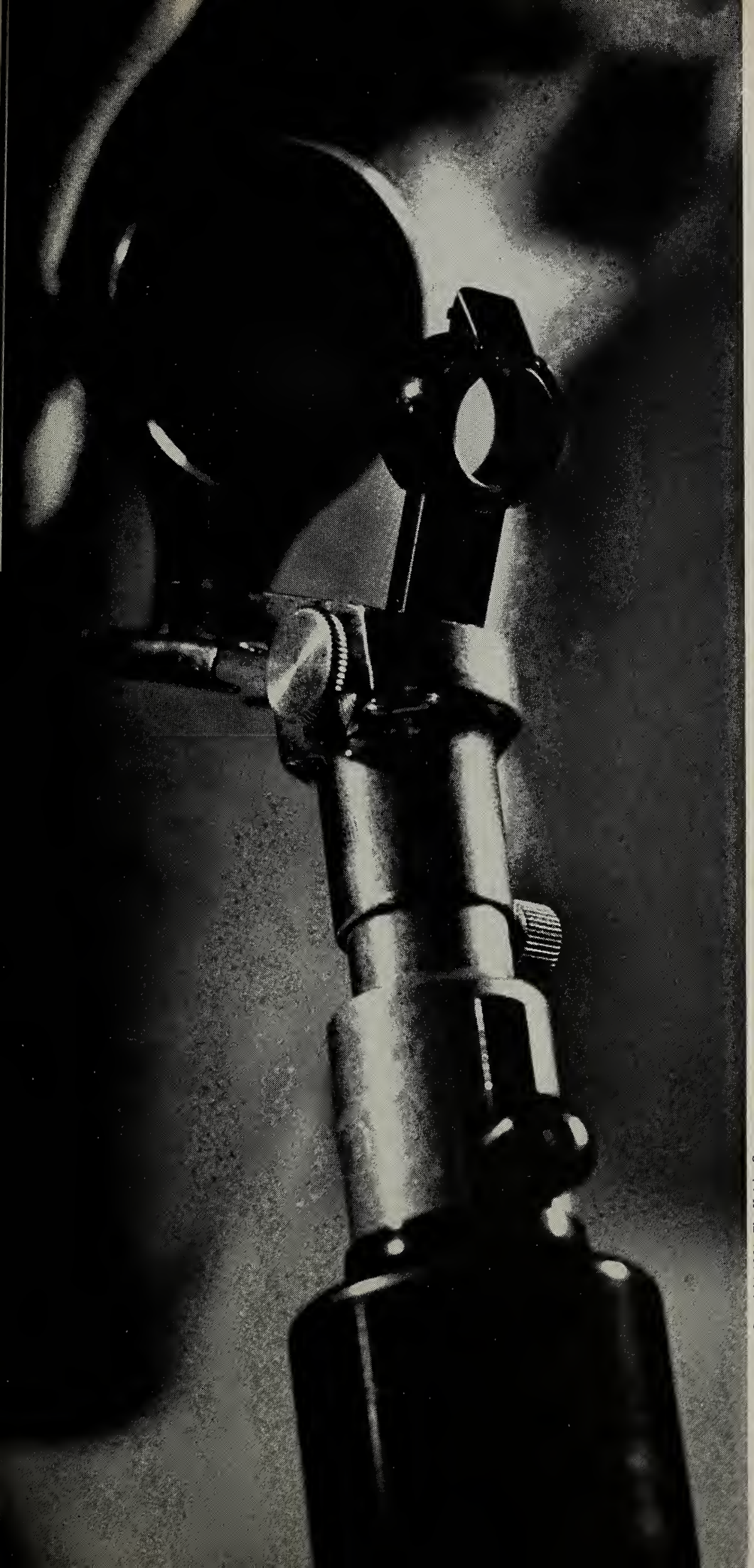
For more details write the Association at 620 N. Michigan Ave., Chicago 11.

Mercy Hospital Alumni to Meet

The Mercy Hospital Interns and Residents Alumni Association will have its annual reunion in Chicago October 20 and 21. A two-day clinical program will be presented in the John B. Murphy Memorial Amphitheater on Friday and at Mercy Hospital on Saturday.

The luncheon and business meeting will be held at the hospital on Saturday and a dinner

(continued on page 12)



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SIDE EFFECTS: Panmycin Phosphate has a very low order of toxicity comparable to that of the other tetracyclines and is well tolerated clinically. Side reactions to therapeutic use are infrequent and consist principally of mild nausea and abdominal cramps.
Albamycin also has a relatively low order of toxicity. In a certain few patients, a yellow pigment has been found in the plasma. This pigment, apparently a metabolic by-product of the drug, is not necessarily associated with abnormal liver function tests or liver enlargement.
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All former alumni and friends are cordially invited. For further information contact Dr. John M. Coleman, president, at 2015 E. 79th St., Chicago—REgent 1-3131.

Symposium on Cosmetic Problems

The Committee on Cosmetics of the American Medical Association will sponsor a Symposium on Cosmetic Problems in General Practice in conjunction with the annual meeting of the Southern Medical Association in the Dallas Memorial Auditorium, Dallas, Texas, on November 8.

Dr. Stephen Rothman, professor emeritus of dermatology at Argonne Cancer Research Hospital and chairman of the Committee on Cosmetics, will act as chairman.

Jottings on Meetings

The *American College of Chest Physicians* will hold its annual Interim Session at the Brown Palace Hotel in Denver, November 25-27. Panels, round table luncheon discussions, and fireside conferences are scheduled.

Illinois physicians who will participate are William B. Buckingham, Edwin R. Levine, William E. Adams, Aldo A. Luisada, Burgess L. Gordon, David Goldfinger, Albert H. Andrews, Frederick N. Lindauer, Andrew L. Banyai, and Donald Unger, all of Chicago; Otto L. Bettag, Glen Ellyn; and Charles K. Petter, Waukegan.

Subjects to be discussed are diagnosis and treatment of congenital and acquired cardiovascular diseases, pulmonary infections, emphysema, and pleural effusions. Other topics are diagnosis and treatment of coronary insufficiency, evaluation of drugs for treatment of heart failure, inhalation therapy, bronchitis and bronchial asthma, carcinoma of the lung, chronic cor pulmonale, paroxysmal tachycardia, and diseases of the esophagus.

To obtain a program write Murray Kornfeld, executive director, 112 E. Chestnut St., Chicago.

The *Society of Medical History of Chicago* invites its members and guests to its open meeting on Wednesday, October 18, at 8 p.m. in the Assembly Room of the Institute of Medicine. Dr. Leo M. Zimmerman, chairman of the department of surgery, The Chicago Medical School, will speak on "The Contributions of Surgery to Modern Clinical Education"; and Dr. H. Stanley Bennett, dean of the Division of the Biological Sciences, University of Chicago, on "The History of Some of Our Concepts of Muscle Structure."

A *Conference on Obesity and Adolescence*, sponsored by the AMA Council on Foods and Nutrition, will convene October 21 in Cubberly Auditorium at Stanford University, Stanford, Cal. Moderator will be Dr. Norman Kretchmer, head of pediatrics at the University.

Five *postgraduate courses* are planned by the Medical College of Georgia, Augusta, for the fall and winter of 1961-62. The courses are Advances in Pediatric Diagnosis and Treatment, October 31-November 2; Fractures in General Practice, November 14-16; Obstetric Problems in Private Practice, January 23-25; Cardiac Emergencies, February 13-15; and Pre- and Postoperative Care, March 20-22. They will be presented by members of the college faculty and guest lecturers.

Each course is acceptable for 18 hours of credit by the American Academy of General Practice. To apply contact Dr. Claude-Starr Wright, Director, Department of Continuing Education at the College.

The *Section on Ophthalmology and Otolaryngology* of the Southern Medical Association will meet in Dallas, Texas, November 6-9 with a program featuring TV surgical clinics on glaucoma and laryngectomy. There will also be papers and symposiums on corneal diseases; contact lens; retinal detachment; tympanoplasty; otitis media; and tonsillar techniques.

Dr. Trygve Gundersen of Boston will be the guest speaker.

For additional information contact the secretary, Dr. Albert C. Esposito, First Huntington National Bank Building, Huntington, W. Va.

The ILLINOIS Medical Journal

Official Journal of the Illinois State Medical Society

Volume 120, No. 4 October, 1961

Some Practical Aspects of the Antidepressant Drugs

David M. Jordan, M.D.,* *Danville*

First of all, I had better make clear what I consider a depression. My experience has been that there is a constellation of physiologically determined signs and symptoms that indicate the presence of a neurophysiologic substrate to depression. Ignoring this substrate is as great an error in judgment as if one were to leave untreated the psychogenic and psychologic aspects. This constellation of physiologic signs and symptoms consists of the following: daytime variation in mood, energy, and quantity of tension, usually worse on first awakening and improving towards afternoon; sleep disturbance, usually no difficulty in going to sleep but when sleep is broken, difficulty in going back to sleep, and especially early morning awakening; disturbances in appetite, usually loss of appetite (This must be asked about most specifically.); and psychomotor retardation, a frequent finding and when present in mild degree, often missed.

*Medical director, Eastern Illinois Mental Health Unit

Other symptoms present in varying degrees are weight loss, obstipation, reduction in sexual drive, change in the menstrual cycle, and a wide variety of physical complaints usually centering on one body system, organ, or orifice.

Symptoms of Depression

To delimit further, I am deleting from this presentation both the manic-depressive reactions and the involutional psychotic reactions. This leaves, then, the so-called neurotic depressions, psychotic depressions, endogenous depressions, and schizoaffective reactions. In simplest form these depressions consist of the physiologic symptoms above plus the patient's feeling cut off from his usual activities and interests be-

cause of an inability to invest them with the customary feeling tones. In addition, in varying degree one finds feelings of uselessness, helplessness, and hopelessness, an inability to concentrate and to make decisions. Always there are the patients' underlying convictions that little or nothing can be done for them. Overwhelmingly, these people experience the symptom complex as ego alien and show some degree of concern (in marked contrast to the psychotic depressives who feel that they deserve their meloncholy state). The reactions under discussion are most likely to begin in the spring or fall. I find them more common in women than in men. The full course of the illness when not specifically treated (by electroshock therapy or the antidepressants) is 18 months with a spontaneous recovery by the end of two years.

The causes can be described rather adequately in terms of two common denominators that produce quantities of stress overwhelming to the stable psychologic functioning of the ego. First, a chronic, unrelenting, and unsolvable life situation of which the person may or may not be aware; and second, loss or threat of loss, real or "imagined." Often patients, because they are depressed, are unable to give any sort of insightful history. Furthermore, there is no pattern to the symptoms of their illness. They must be questioned so that the physician can develop and diagnose the clinical picture.

The whole problem of diagnosis and treatment of these depressions is complicated because they are *exceedingly often masked.* I have arrived at the point in my thinking where I consider the basic depressive pattern, outlined above, as the base line upon which the susceptible individual will develop one or more of the following defensive patterns: *neurotic regression,* with varying amounts of anxiety, hysterical, and/or obsessive compulsive symptomatology; or *intense somatization* and marked hypochondriasis (Along with these defenses come repeated physical examinations from numerous doctors with no findings sufficient to explain the symptom picture.); or with *acting out,* usually an intensification of symptoms already present or an alternating between increased acting out and bouts of intense depression with recourse to alcohol; or, finally, with *psychosis.* Thus I have seen some of these people under the grinding force of the depression become less and less able to function ego-wise as shown by an early psychotic depressive coloring or even a schizoaffective camouflage.

Treatment

The depressions, with or without the above "masking" complications, I find are quite treatable with the monoamine oxidase regulators or inhibitors, usually in conjunction with one or two other types of medication. The patients are on the antidepressant medication a minimum of four months. They start with one tablet three times a day after meals until symptom relief is evident to the patient and the physician and until the person becomes more hopeful, determined, and purposeful. At this point I usually reduce medication to one tablet twice a day. The drug acts slowly in most cases. Clear-cut results may not be identified by the therapist and certainly not by the patient until eight to twelve weeks have passed. Usually before this period some indications of improvement are identifiable by the patient's family or the therapist. At the end of three to four months the dosage may still be two tablets or, often, one tablet a day. When the patient can successfully maintain his new level of adjustment on one tablet per day for a month, I have him test the need for the medication until it becomes clear whether he requires the drug indefinitely. Results in my patients have been uniformly excellent in the depressions as outlined above, in the depressions of ambulatory schizophrenics, and in the more typical schizoaffective reactions.

The strongest of the monoamine oxidase (MAO) inhibitors are Marsilid® (replaced by Marplan®) and Catron.® Most therapists now use Marplan, Nardil®, or Niamid®. Tofranil®, apparently not a MAO inhibitor but chemically related to the phenothiazines, also produces similar results. Because of the intensity of the neurotic regression, the somatization, the acting out, or the presence of psychotic trends, other medications often should be added. Meprobamate, Permitil®, and Librium® are most frequently used to alleviate anxiety; Dexedrine®, Ritalin®, or Tofranil, to enhance the antidepressive effects. Sleep is so often such a severe

problem that a sedative is needed. I use either Carbrital® or Nodular®, 10 to 15 tables per prescription, marked refillable once in order to keep close medical control. When there is lack of cooperation or any suicidal risk, I turn all medications over to a responsible member of the family with careful instructions, such as to keep a count of all the tablets, to hand out the pills, and to make sure the patient takes them.

Side Effects

Important side effects of medication are giddiness (the most common), drowsiness, obstipation, reduced libido, swelling of the feet, and paresthesias of the feet and legs. Modification of the dosage to two tablets one day and three the next on alternating days often helps. Sometimes a diuretic is necessary if there is swelling. Vitamin B complex by mouth is most effective in correcting the paresthesias of the feet and edema. The greatest danger is the toxic effect on liver function. This is hard to detect early solely through listening to the patient's complaints. A transaminase determination, available in any up-to-date hospital laboratory, is probably our earliest indicator of liver toxicity. This is done every 10 to 14 days. With some indication of liver involvment, the MAO inhibitors must be reduced to a minimum or even discontinued. Under such conditions, the transaminase determination should be done every few days to see if the drug must be discontinued completely or if it can be gradually built to more effective but lesser dosage.

On the positive and unexpected side of things, these drugs relieve intense anxiety as well as depression in a number of patients; they are found to have definite reparative and recuperative effects also on those with a chronic, debilitating illness or with a prolonged convalescence.

Similar physiologic states can be shown in laboratory animals under prolonged stress, and they are accompanied by decreased amounts of two neurohormones, serotonin and norepinephrine. The enzyme, monoamine oxidase, inactivates these two neurohormones; so administering a chemical that inhibits or regulates the amounts of monoamine oxidase results in increased quantities of the two neurohormones. Serotonin is akin to the sympathetic-like drugs that promote alarm reactions expressed in fight or flight responses to immediate stress. Norepinephrine is akin to the parasympathetic-like drugs that promote sustained physiologic responses dealing with prolonged stress. Serotonin and norepinephrine are produced in the tissue of the central nervous system and, therefore, exist throughout it. They are intimately connected with neural functioning at all levels and are essential to stable operation of the central nervous system and to easing adaptation to situations calling for greater or lesser amounts of one or both of these hormones.

I have often been intrigued with the thought that an animal developing one of these "physiologic depressions" would vastly simplify its environment. But human beings, because of their cultural indoctrinations and the complexities of their psychologic functioning, are not able to adapt in such a simplified way. This line of approach makes me speculate further that the change in functioning or physiologic adaptation of the human nervous system in terms of reduction of output of the neurohormones could be a physiologic defense that keeps the organism from going on to complete exhaustion and death or into a severe physical illness.

Evaluation

I have been using these drugs for two years, and I do not yet know whether the patient remains vulnerable throughout the two-year period and will eventually need a repeated course of medication. With the majority of patients, I have been able to discontinue the antidepressants within three to six months. There have been a few who have obviously done much better on a daily maintenance dose. These drugs, producing such a marked increment in ego functions, obviously are most helpful adjuncts to psychotherapy. No treatment of a depression is complete without a concerted attempt to evaluate and then to communicate the intra- and extra-psychic factors responsible for the illness in the first place. I consider this group of drugs a breakthrough in psychiatry comparable, in fact, to discovery of antibiotics in clinical medicine.

The Diagnosis of Ovarian Cancer

Larry McGowan, M.D., *Chicago*

Primary malignancy of the ovary is the third most common cancer of the female reproductive organs. Its importance is secondary only to cervical and endometrial carcinoma.[1]

It may occur at any age—in childhood, adolescence, the reproductive years, and following the cessation of menstruation. These tumors may be unilateral at a very early stage and bilateral soon thereafter. Cancerous ovaries may be slightly enlarged or of great size. They may be solid, semi-solid, or cystic and may be freely movable or adherent to adjacent tissues.

Cure depends on early detection and prompt and appropriate therapy. Unfortunately, the anatomic structure and location of these glands and their neoplasms do not facilitate early detection.

Incidence

Primary ovarian cancer accounts for 4 to 6 per cent of all cancer occurring in women, and about 10 per cent of all gynecologic cancer. A woman at age 40 has nearly a one per cent (.930) chance of subsequently developing this neoplasm. The probability gradually diminishes to 0.5 per cent at 65 years of age.[1] Approximately 18 per cent of ovarian cancers are found in women age 40 and younger, 61 per cent between age 40 to 60, and 21 per cent over 60 years of age.[2]

Symptoms

Ovarian malignancy is usually asymptomatic in the early stages. Mechanical accidents such as torsion, rupture, or hemorrhage of a benign cyst force recognition in an emergency. Pain may call attention to an associated early malignant lesion in these cases. Vague gastrointestinal complaints and abdominal pain are associated with dissemination of the disease. Abnormal uterine bleeding, even though noted early by the patient, usually means metastasis to the uterus.

Diagnosis

The woman who presents herself with advanced ovarian cancer is not a difficult diagnostic problem. The abdominal findings include enlargement, fluid in her flanks, a mass in the suprapubic area, and a secondary omental epigastric mass. The pelvic examination reveals fixed masses filling the vaginal fornices and posterior cul-de-sac. When the diagnosis is made at this stage of the disease, all forms of therapy are of little value.

Considerable growth may take place in the ovary before the patient realizes something is amiss. The organ is mobile, and abnormal growth does not encroach early on vital organs. The periods of its outward quiescence in the years prior to the menarche and after the menopause may lull both patient and physician into an unfounded feeling of security.

The fact that long term salvage in ovarian cancer is poor, demands further exploration of the methods already utilized for diagnosis. We must investigate the possibility of redirecting them toward earlier detection of ovarian cancer and consequently greater survival.[3]

Cytologic evaluation of cervical scrapings and posterior vaginal pool accumulations are of limited value in the diagnosis of early carci-

From the department of obstetrics and gynecology, Stritch School of Medicine, Loyola University, Chicago

noma of the ovary.[4,5] However, the occasional case with persistent postive exfoliated cells from the vagina or cervix with no apparent malignancy of the vagina or uterus should make one consider an ovarian cancer.

Exfoliated malignant ovarian cells are found in the peritoneal space prior to surgery and manipulation in a significant number of cases of ovarian cancer. Utilization of this information has led to the investigation of fluid aspirated from the cul-de-sac. This is an attempt to withdraw or wash out malignant cells in the peritoneal fluid in an effort to make earlier diagnosis,[6] or at least a more certain preoperative diagnosis. Techniques for examination of ascitic fluid for malignant cells are being perfected.[7] This diagnostic tool will have to be given careful consideration when various groups probing into this approach present their results. Cassidy, from his studies, states that the prognosis with positive peritoneal fluid is grave.[8]

The aspiration of questionably malignant cysts of the ovary either by way of the vagina, transabdominally, or under direct vision at the time of surgery should never be performed. The possibility of malignant tumor-cell dissemination is an insurmountable hazard.

The signficance and future application of detecting cancer cells in the blood in relation to ovarian malignancy must be awaited.

The age of the patient and size of the ovaries are important considerations. An ovary approaches in size those of an actively menstruating woman during the accelerated period of growth and development of secondary sex characteristics that precedes the menarche. During the years of menstruation, the ovaries are usually 2-5 cm. in length, 1-3 cm. wide, and 1-2 cm. thick with cyclic variations ordinarily within these limits. There is a gradual diminution of size with each succeeding year following the menopause. At genital senescence they may be no more than 2 cm. A woman at age 35 or over demands more active management than a younger woman with ovarian enlargement.

Hormone-producing ovarian tumors—granulosa-cell tumors and arrhenoblastoma—should be removed without hesitancy because of their malignant nature and their undesirable secondary effects.

The ovaries should always be examined postmenstrually in order to avoid confusion with physiologic enlargement. If uncertainty persists after examination, this is the opportune time for the gynecologist to utilize diagnostic posterior colpotomy and culdoscopy.

These two diagnostic procedures may prevent unnecessary abdominal surgery by visualization of normal ovaries. Low morbidity, a short hospital stay, and minimal patient discomfort are experienced. Good visualization of the ovaries in women of menstrual age is possible but, because of mechanical problems, may not yield as high a per cent of good visualization in the girl prior to the menarche and the woman many years postmenopausal.

The abdomen should be opened after a preoperative diagnosis of ovarian cancer. The gross pelvic findings at the time of surgery are very helpful. The extreme lobulation of solid ovarian tumors, plus fixation of the ovary to adjacent tissue, scattered tumor nodules, and metastatic involvement of the omentum and liver are evidence of ovarian cancer.

The early and small malignancy lesions introduce a challenge at the operating table. Such factors as size, color, consistency, and presence or absence of papillary excrescences on the ovary require deliberation.

Abundant external papillary excrescences on a discolored, enlarged ovary in the presence of increased quantities of peritoneal fluid which may be blood-tinged is ovarian cancer till proved to the contrary at any age.

The value in utilization of frozen section pathologic examination of tissue concurrent with surgery to verify ovarian cancer is restricted. The reason is that it is difficult to obtain a representative area of some ovarian neoplasms. Pathologists and gynecologists alike encounter difficulty in interpreting histologically borderline or early ovarian malignant tumors.

Differential Diagnosis

The physician, in his desire to ferret out this insidious malignancy, has to guard against becoming overzealous in his earnest attempt to differentiate benign from malignant lesions. An accurate past medical, surgical, and menstrual history is necessary.

His task may be confused by the occasional

presence of nonneoplastic cysts of the ovary. Slight variations or pathologic conditions of adjacent organs entering the pelvus may conceal a correct diagnosis.

The following should be considered:

1. Nonneoplastic cysts of the ovary
   a. Follicle cysts-hematoma
   b. Corpus luteum cysts
   c. Multiple lutein cysts
   d. Germinal inclusion cysts
   e. Endometriomas
   f. Polycystic ovaries
2. Distended bladder
3. Feces in rectosigmoid area
4. Adherent bowel and omentum secondary to previous surgery or infection
5. Variations in the position of the cecum and sigmoid colon
6. Tubo-ovarian tumefactions
7. Parovarium cyst
8. Fibroids—pedunculated parasitic, intraligamentous—of round ligament; cystic degeneration
9. Tubal gestation with hematosalpinx
10. Appendiceal abscess
11. Pelvic kidney or polycystic kidney
12. Carcinoma of sigmoid colon
13. Diverticulitis—secondary complications

Diagnostic aids such as sigmoidoscopy, barium enema, and intravenous pyelography will help to establish extragenital pathology.

Therapy and Prognosis

Once the diagnosis of primary malignancy of the ovary is established, surgical extirpation of the uterus, tubes, ovaries, omentum, and any space-occupying metastasis that is accessible to resection is indicated. There are physicians who choose to remove only the apparently involved ovary in young women with early ovarian cancer of low grade malignancy. This course of therapy is difficult to follow with the realization of a high per cent of bilateral ovarian involvement, and a poor salvage rate in ovarian cancer.

The utilization of adjunctive chemotherapeutic agents, radioactive gold,[6] and external irradiation,[9] is undergoing widespread investigation in an attempt to increase length of life in women with ovarian cancer.

The results of treatment of malignant ovarian tumors, as measured in 5 year survivals, range between 10 and 50 per cent with a figure between 20 to 30 per cent usually quoted.[9] The widely divergent statistics are partially due to differences in histologic criteria of malignancy, which are sometimes obscure in the papillary serous cystadenoma group. In addition, granulosa-cell tumors, although neoplastic, are associated with greater patient longevity than the usual ovarian cancer, and a disproportional increase in these tumors will increase the percentage of survivals.

We have only to compare our present over-all patient survival rates of ovarian cancer with those of 20 years ago as reported by Meigs,[12] and we see minimal progress.

Discussion

Women with ovarian cancer have a higher sterility rate than other married women.[2] Consequently, delayed pregnancy may delay early pelvic examination. Greater patient education and routine bimanual rectovaginal examinations every 6 to 12 months in women age 30 and over will result in early detection.

It has been proposed to routinely remove the ovaries during hysterectomy after age 45 as a prevention of ovarian cancer. This would only eliminate the probability of less than 1 per cent (.882) of women of this age developing ovarian carcinoma during the remainder of their lives. The probability of a woman developing any malignancy decreases rapidly after her fiftieth year.[13]

Randall[13] has stated it well: "That unless it can be shown that after her climacteric a woman derives no benefit from the preservation of her ovaries, prophylactic removal seems unwarranted by the mere probabilities of ovarian pathology."

Conclusions

During the active menstrual years, ovarian enlargement should be evaluated after menses for one to two months. If over 5 cm., the ovaries should be visualized; if greater than 7 cm., surgical exploration is indicated. The closer a woman is to her menopause the more stringent the investigation.

Depending on the proximity to the menarche or from the menopause, ovarian size will determine management and the need for surgery.

During these extremes of life, ovarian enlargement over 3 to 4 cm. should be observed closely for a short period of time prior to more active management.

There is close correlation between estimating ovarian size by palpation and actual size. After inconclusive pelvic examinations and routine diagnostic procedures are exhausted, posterior colpotomy and culdoscopy are advocated. They help discover ovarian carcinoma at an earlier stage, and increase survival.

Summary

1. Primary ovarian cancer accounts for 4 to 6 per cent of all cancer occurring in women and about 10 per cent of all gynecologic cancer.

2. It has an insidious onset, and the presenting symptoms are usually those associated with an advanced stage of the disease.

3. The improvement in the present low patient-survival rates must depend on earlier diagnosis.

4. Regular periodic pelvic examinations should be performed on all women over 30 years of age.

5. The visualization of ovaries consistently enlarging over 5 cm. during menstrual life and 3 to 4 cm. at the extremes of life will contribute to earlier recognization of ovarian cancer.

6. Diagnostic posterior colpotomy and culdoscopy are important additions to traditional diagnostic procedures. Their use may replace prolonged observation in the presence of ovarian enlargement.

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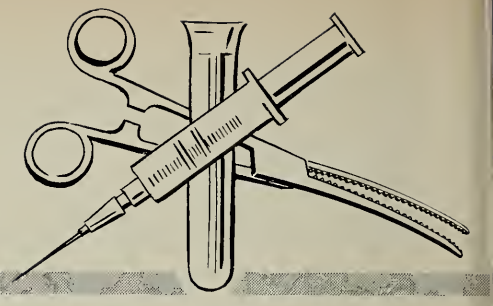
Occupational Medicine

What does an occupational health program cost? Rather than determining total medical costs, the cost per employee is a more illuminating way to judge these costs. In a survey of 135 companies, of the cost of medical services reported in 1956, it was found that 71 or more than half of the companies spent between $10 and $20 per employee per year. Medical services in just under a fourth of the companies cost between $1 and $10 while about 10 per cent of the companies reported costs between $20 and $30. Most of these companies had between 1,000 and 5,000 workers.

The benefits from such medical programs are intangible and difficult to measure, but labor's interest in such programs is indicative of its belief that the employee benefits, and the very fact that industrial medical programs are growing and expanding proves that businessmen judge the programs to be worth more than they cost. In relation to some fringe benefits, the cost of medical service is low, but the return is probably greater.

Looking at the labor force, the industrial physician must recognize that not only the strength of a company but the strength of our nation rests in our labor force. A healthy, happy work group is essential to the welfare of our country, and it is up to the industrial physician to help keep it so.

Occupational medicine is a force for good, and the industrial physician walks side by side with labor and management toward a horizon which promises much for all in improved preventive medicine and occupational health. *L. A. Pyle, Jr., M.D. The Industrial Physician—Where Is He Going? South. M. J. February 1961.*



Clinical · Surgical Conferences

COOK COUNTY HOSPITAL

Renovascular Hypertension

Moderator:
ROBERT J. FREEARK, M.D.
Director, Department of Surgical Education
Discussant:
VINCENT J. O'CONOR, JR., M.D.
Associate in Urology, Northwestern University Medical School; Assistant Attending Urologist, Wesley Memorial and Veterans Administration Research hospitals

DR. ROBERT J. FREEARK: For the majority of patients suffering from high blood pressure, little in the way of curative therapy is available. Nevertheless, each year further progress is apparent in separating from the large group of essential hypertensives a small number in whom a specific cause can be identified and curative measures attempted.

One such group is made up of the patients whose high blood pressure has occurred as a result of interference with the circulation to the kidney. Just as in other forms of vascular disease, the circulation may prove adequate to prevent the death of kidney cells but insufficient to permit their normal function. That the ischemic kidney can cause hypertension has been known for years since the classic experiments of Goldblatt.

The problem presented is a twofold one: first, identification of the occasional hypertensive patient in whom renal vascular disease is responsible; second, doing something about it. That hypertension from any cause tends to exert its deleterious effects upon the function of the kidney greatly complicates efforts to detect these cases; and when one considers the general health of patients with severe hypertension, it is easy to see that operative treatment is not without its hazards.

Wide general interest in this problem is apparent in spite of its infrequent occurrence. The practitioner and internist must be constantly on the alert for correctable causes of high blood pressure. The radiologist must be able to advise and assist in the techniques of detection and evaluation of these patients. The general, urologic, and vascular surgeon must be prepared to deal effectively with the condition once its presence is detected.

With us today to discuss a recent case of renovascular hypertension encountered on the medical and surgical wards of this institution

is a surgeon with outstanding qualifications. Vincent J. O'Conor, Jr., is the son of one of the great urologic surgeons of this country. His background and training have equipped him well for a career of equal brilliance and for his status as an expert in the field of renovascular hypertension. After completing a four year residency in general surgery at the Peter Bent Brigham Hospital in Massachusetts, he elected to obtain two years of additional training in urology. He became interested in the vascular effects upon the kidney in connection with studies on renal homotransplantation, in which he also qualifies as an expert. At present he is a very active member of a group at Northwestern University engaged in the detection and treatment of patients with this condition.

Without further ado, I will ask Dr. McEnery to present the case. This was a long and involved work-up, a very excellent one, carried out by the medical service, and we will present only the more pertinent findings, adding further information when requested by our discussant.

Dr. Eugene McEnery (resident, urologic surgery): The patient is a 55 year old Negro male admitted on Feb. 11, 1961, to Cook County Hospital with complaints of orthopnea and dyspnea on exertion. Up until the last year the patient had been in essentially good health except for asymptomatic hypertension of uncertain duration. He described a rapid deterioration of his health for the last five months. On physical examination the patient appeared chronically ill, was lethargic, and showed evidence of weight loss and dehydration. Blood pressure was 220/120 in both upper extremities, throughout most of the day and night. The remainder of the physical examination was unremarkable except for the presence of a pulsating epigastric mass over which a systolic bruit was readily audible. Peripheral pulses were intact throughout all extremities.

Laboratory study revealed a white blood cell count of 9,000 with hemoglobin of 11.8 Gm./100 ml. and a red blood cell count of 4,100,000. The urine was free of sugar but contained some red cells and white cells in each high power field. A one plus albuminuria was subsequently shown to represent a 24-hour proteinuria of 400 mg. Urine culture revealed paracolon organisms in concentration greater than 10^5; they were sensitive to all antibiotics tested. Representative blood chemistries were as follows:

	2/13	3/21	4/10
Blood urea nitrogen	31.	43.	20.
Creatinine	2.8	2.4	2.2
Creatinine clearance	32.	29.8	
Total protein (A/G ratio)	8.1 (5.0/3.3)	7.1 (4.2/2.9)	

X-ray study revealed an enlarged heart of hypertensive configuration with fusiform dilatation of the thoracic aorta, but without evidence of aneurysm. Scout film of the abdomen revealed decrease in the size of the left renal shadow. Investigation of the urinary tract by intravenous pyelogram revealed nonfunction of the left kidney and visualization of the right kidney five minutes after injection. Retrograde studies were attempted on the left side, but the catheter could not be passed up the left ureter.

On April 6 a translumbar aortogram was performed using a #16 needle and 50% Hypaque®. This demonstrated a fusiform dilatation of the upper abdominal aorta without visualization of the left renal artery or the left kidney vascular pattern. The vascular pattern to the right kidney was interpreted as normal.

The patient was placed on digitalis, Serpasil®, and appropriate supportive measures. A slowly rising BUN (blood urea nitrogen) was reversed only by vigorous intravenous fluid therapy.

On April 14 the patient underwent a transabdominal exploration of the aorta and left renal pedicle.

Dr. Freeark: While this is far from a classic case of renovascular hypertension, I think the patient presented illustrates many of the problems which surround the evaluation and treatment of this disease. I thought we might begin by asking Dr. O'Conor to review the work-up in this patient and indicate the findings of significance.

Dr. Vincent J. O'Conor, Jr.: The first thing I noticed is the age of this fellow; it is a good age for renovascular hypertension. It would be helpful if we knew exactly how long he had

had hypertensive disease; the factor will come out as we talk about what we think might have been done. On the plain film and urogram, the left kidney was quite small, which is fairly significant in terms of duration of the disease. I would not agree entirely with the interpretation of the aortogram. The right renal artery looks a little large to me, and I would suspect a block of the ostium of the main renal artery as well as partial obstruction of one of the distal branches. We can see on this angiogram that the terminal vessels in this right kidney do not fill out well. This is very significant to us in showing parenchymal disease within the contralateral kidney. This is a factor we are particularly interested in for deciding whether or not we can cure the patient by appropriate surgery. The finding of a persistently elevated BUN is a most ominous sign.

Maybe we could start with some slides, running through the subject as a whole, and then come back to this case and discuss what one might do and what the result might be.

The first slide is a general classification of hypertension. A small but definite number of these conditions are surgically curable (Table 1). The next slide shows some of the different causes of renal arterial insufficiency (Table 2). The numbers on the right were the findings in the first twenty patients who were operated upon in our hospitals. As you see, the most common cause was an arteriosclerotic plaque in the renal artery. The next slide is a graphic representation of these findings (Fig. 1). We have, for instance, plaques at the take off of the renal artery, which I think this patient may have had. Plaques may form and obstruct branches as well, and thrombi can form by themselves or in conjunction with a plaque.

TABLE 1.—Classification of Hypertension

A. Primary (Essential) Hypertension	
B. Secondary	
1. *Endocrine*	
a. Hyperthyroidism*	
b. Pheochromocytoma*	
c. Cushing's syndrome*	
d. Primary aldosteronism*	
2. *Neurogenic*	
a. Brain tumor*	
b. Bulbar neuropathic polio	
c. Acute porphyria	
3. *Cardiovascular*	
a. Coarctation of aorta*	
b. Arterio-venous fistula*	
c. Generalized arteriosclerosis	
4. *Renal*	
a. Congential polycystic disease	
b. Glomerulonephritis	
c. Advanced chronic pyelonephritis*	
d. Wilms tumor*	
e. Renovascular disease*	

*Curable by surgery

TABLE 2.—Common Renovascular Lesions

1. Congenital stenosis of renal artery (Fibrous Intimal Proliferation)	
2. Syphilitic arteritis	
3. Renal thromboangiitis	
4. Renal embolus	
5. Renal artery aneurysm	(1)
6. Renal artery thrombosis	
a. Occlusion of main artery	(1)
b. Occlusion of secondary branch or aberrant artery	(3)
c. Associated with A/S plaque	(1)
7. Arteriosclerotic plaques	(16)

Figures in parentheses represent findings in the Northwestern University experience.

The next slides emphasize an interesting and important phenomenon. They are from a study of renal transplantation in which our primary concern was with the ureter. However, in this dog a definite narrowing developed at the renal arterial anatomosis. This was six months postoperative, and I show it because this is comparable to what we see in the human. The major gross change is contraction of the kidney, a small kidney. The microscopic changes that occur after long-standing ischemia are very subtle. In the beginning there is very little in the way of change, and reversible lesions may produce no histologic change with standard techniques. The eventual result is a contracted kidney with a gross loss of renal substance. The tubules have atrophied and disappeared, and there is a jamming together of the glomeruli. Here you see a slide of the kidney from a patient who had hypertension for less than three months. He had a very definite arterial block as shown on the angiogram, but this was interpreted histologically as a normal kidney. There are essentially no changes. The tubules are quite normal-appearing as are the glomeruli. The important point is that early in the game when the patient is curable without a

doubt, the changes may be minimal. Let us compare this kidney with that of a patient who was hypertensive for over a year. You can see more progression of the disease with crowding

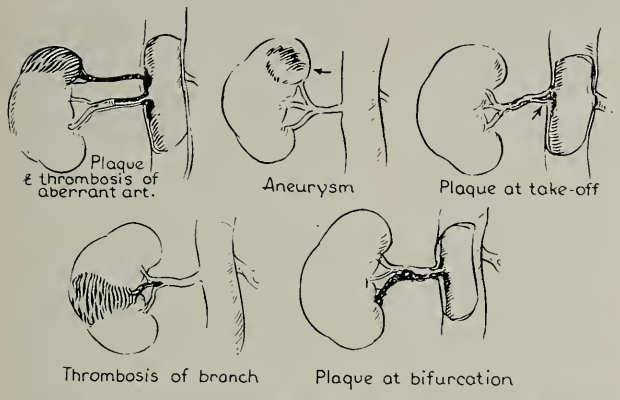


FIGURE 1. Location of renovascular lesions that cause renal hypertension.

of glomeruli, a loss of tubules, and a little more interstitial fibrosis. Though subtle, the changes are clearly more advanced.

Another point to remember is that the changes in the affected kidney are probably not as important as the changes in the contralateral or normal kidney. In other words, the contralateral kidney propagates the hypertension following surgery. All our present tests are directed at evaluating the function of the other kidney in terms of prognosis. Since this may be difficult, one wonders if we should not be doing percutaneous biopsies of the good kidney in these patients. With this brief review of the pathologic process, let me attempt an approach to the clinical problem.

Let us first consider some of the important factors about this disease. The history and the age of the patient are extremely important. Anyone under 35 who develops hypertension has an extremely good chance of having some secondary cause, whether it be endocrine, neurogenic, or renal. The age group of essential hypertension is usually in the mid-forties to mid-fifties; however, no age group is exempt. In nine patients whom we consider cured, four were in their forties and five were over fifty, so this disease can occur in any age group.

The onset we think is very important. Many of these patients will give a history of a very sudden onset associated with abdominal or flank pain. One woman developed extreme anxiety, palpitation, and nervousness about 10 o'clock at night. Her family physician found a systolic pressure of over 200 and a diastolic pressure of over 100. She had been normotensive two months before. A sudden onset is significant. Associated pain can be from the plaque breaking off or sudden occlusion of a renal vessel.

Physical findings in our experience are much the same as you will find in any other hypertensive. The presence of bruit over the kidney is suggestive, not only of narrowing of the renal artery but of the abdominal aorta. We have heard this in renal arterial disease, particularly with aneurysm, so it is worth listening for over the upper abdomen and the flank area in every hypertensive. The urinary findings are of no value because I do not think you can cure the patient by surgery if the urinary findings are significantly abnormal. In our experience the ganglionic blocking tests have not helped at all.

A great deal of information is provided by intravenous pyelogram in some cases. There is no question that early in the disease and particularly when the patients are curable, the intravenous pyelogram may be perfectly normal. In spite of significant arterial narrowing, there may be no delay in concentration and no change in the size of the kidney. As the disease progresses, we first note a delay in excretion. Later there is decreased concentration, a decrease in size and finally nonvisualization, as in the case presented. Any of these changes with a normal calyceal pattern on retrograde study are suggestive of renovascular disease from either arterial or venous obstruction. The important point again is that *early* there may be no changes on the pyelogram.

Let me illustrate with a few examples. Here is the intravenous pyelogram of a woman who had the very sudden onset of symptoms. The five-minute film shows good excretion. She had a calcified mass in the lower pole of the left kidney, and at surgery we found a pulsating saccular aneurysm involving the whole lower pole of the kidney. Following removal of the kidney, she was immediately cured of her hypertension and has remained so.

The next is a patient whose intravenous pyelogram revealed a kidney with faint visualiza-

tion on one side. In spite of this, a normal retrograde film was obtained. These are the typical findings with arterial obstruction.

We have made use of an additional diagnostic test called the radioisotope renogram. This is a simple test, when you have the equipment to do it. It involves injecting intravenously a small amount, usually less than 1 cc. of radioactive I^{131} labelled Hippuran®. This substance has replaced Diodrast®, which we used previously. After injection of a small tracer dose, scintillation counters are placed over the two kidneys and measure the differential function between the two. After the material is injected, there is a rapid spike upward which represents the initial pick-up of blood going to this kidney. There is a second spike which indicated accumulation within the tubules of the kidney, and finally the so-called excretory phase as the material passes down the ureter. Here you see a tracing from a patient who had arteriosclerosis on the right side, and we see a decrease in the vascular spike and a slight prolongation of the secretory phase on this side. This response suggests very early renal tubular damage.

A more common finding in patients with marked renal arterial obstruction is a lowering of the vascular spike and marked diminution of function on one side. This usually signifies that very little of the material is being picked up and excreted by the kidney.

The radioisotope renogram is extremely useful for screening large numbers of hypertensive patients. It is much more accurate for screening than is the intravenous pyelogram. It has a very minimal cost; they may be obtained at Northwestern University Medical School for less than $10 each. The amount of radiation encountered is less than that received during a plain chest x-ray.

Similar results may be obtained by the so-called split function studies in the detection of unilateral renal disease. In this condition the kidney which is ischemic will tend to put out less water and less sodium. The mechanism involved is complex, and I will not discuss the physiologic basis. The important fact is that the affected kidney, i.e., the one with vascular impairment, puts out less water and sodium than the opposite kidney.

One test that I think is extremely clever was reported last year by Rapaport in the *New England Journal of Medicine.* It obviates the problem of leakage around the ureteral catheter which often interferes with accurate split function studies. He has shown that as sodium excretion falls on the affected side, the creatinine goes up. So all you have to do is collect a sample from the two sides, measure the sodium to creatinine ratio, and you have this pinpointed, irrespective of any leakage you may have. It is a good test. In going over some 50 patients we have subjected to the more expensive split function tests, we find that this simple measurement of volume, sodium, and creatinine works just as well.

The split renal function studies are helpful in making the diagnosis, particularly in a patient with a normal intravenous pyelogram. If the intraveonus pyelogram is normal, the radioisotope renogram is normal, and the split function test is normal, then we will *not* do renal angiography. If, however, any of the three tests is abnormal, angiography is usually indicated. The injection of contrast media into the aorta in order to visualize the renal vessels is not without risk. Nevertheless it is essential to definitive diagnosis.

We never operate upon a patient without angiography as we like to know what the other renal artery is like, and particularly what the splenic artery is like. Let us now run through some representative angiograms. The first is an example of a fairly early case. We still use the translumbar approach in which the contrast media is injected directly into the aorta. Though undoubtedly safer, the intravenous method has not given us good visualization. This patient shows a fairly good aorta and a good left renal artery and an excellent splenic artery. Here, you will note a lack of filling and just beyond this an area of poststenotic dilatation. Finally we see a definite occlusion. This patient had a plaque at the take-off as well as extensive atheromatous plaques throughout the aorta (Fig. 2).

The next film (Fig. 3) shows delay, using the rapid changing casette. We see here two things. First, the shadow that you see with an intravenous pyelogram, the so-called nephrogram, is quite dense on one side and very light on the other. When you cannot see the

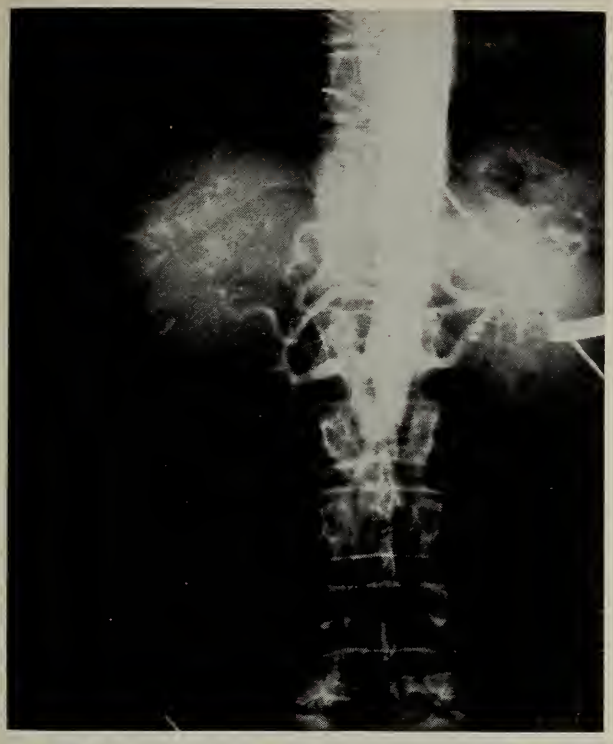


FIGURE 2. Aortogram of a 56 year old man with arteriosclerotic plaque obstructing proximal segment of right renal artery. Note poststenotic dilation.



FIGURE 3. Delayed film shows decrease in both renal size and concentration of contrast material (nephrogram) on right.

block, you may see a decrease in filling with contrast media and have a suspicion that there is a block in the renal artery. Here the intravenous pyelogram was normal, but the kidney is definitely smaller on the affected side.

Now just a word about surgical techniques available once the diagnosis is made. I think the difficult thing to decide is whether to operate or not. The second thing is to decide what to do. If you are on the left side, no matter where the block is, and if you have a good artery distal, it is simple to swing down the splenic artery to the area of poststenotic dilatation and anastomose it. You do not have to remove the spleen as there are usually good collaterals coming back from the short gastrics, so leave the spleen in and use the splenic artery. Some people have swung this over to the right with good results, but often it is too tortuous. Homografts may be used to bridge the defect, but our present preference, when feasible, is endarterectomy with patch grafting.

An important decision is whether to attempt arterial reconstruction or perform nephrectomy. In this regard several findings in the patients that we have cured and that other people have cured of this disease are significant in retospect (Table 3). Dr. Chester Winter, professor of urology at Ohio State University, devised a system for predicting which patients might be cured by nephrectomy or a definitive reconstructive procedure on the artery. What he did was go over the associated findings that were present in the patients reported to have been cured. The first factor is the age of the patient: the younger the patient the greater the likelihood of cure. Women with this disease have a markedly increased cure rate, and why this is

TABLE 3.—Prognostic Factors in Renovascular Hypertension

1. Age
2. Duration of hypertension
3. Differential renal function tests
4. Differential volume studies
5. Total renal function (blood chemistry)
6. Radioisotope renogram
7. Renal angiogram (aortogram)
8. Intravenous pyelogram

so I do not know; but in this system more points are given to women.

Another consideration is the duration of the hypertension; a duration of less than ninety days receives the most points and the longer the hypertension has been present the fewer the points.

In addition, comparative individual renal function tests are important. This has been set up very simply. The important thing is the ratio of one kidney to the other; when excretion is equal between the two kidneys, no points are given, and when there is a marked discrepancy between the two kidneys, more points are given. Also important are volume differences between the two kidneys. A large volume differential receives more points.

Lastly a most significant factor is the total blood chemistry. This could be obtained by any of the standard methods, creatinine, BUN, creatinine clearance, or a well-controlled PSP (phenolsulfonphthalein) study. We have never seen a patient with unilateral renal artery disease who had an elevated BUN or creatinine cured by nephrectomy. I consider this extremely important. We do not feel that any person with an elevated BUN or creatinine with renovascular disease should have nephrectomy. If anything, a reconstructive procedure should be carried out.

The main point in Dr. Winter's method is that you get the most points the closer to normal the findings. In other words, the earlier changes give a greater chance of cure.

Along these same lines, in aortography, points are taken off when the kidney does not visualize, particularly if there are bilateral lesions.

With intravenous pyelography, points are taken off as you go, according to the severity of the changes noted on the pyelogram.

Our evaluation in retrospect of the 20 patients we have operated upon is presented here. The magic figure in this scoring system is 28 points. None of the nine patients in whom we were unable to relieve hypertension scored over 27 points. In contrast, we might cite 9 others. Two of these were considered controlled and 7 were cured. All of these scored well above the 28 figure. The only one that did not fit this scheme was a man who had a bilateral endarterectomy. He would not have been cured with nephrectomy but was by this procedure.

The findings from two patients who were not cured by surgery are particularly significant. They had been studied one and a half and two years previously and had been completely evaluated. They either rejected surgery or were advised against it and then came back, were re-evaluated, and operated upon without benefit. We thought that both of them, when they were first seen, should have been cured by nephrectomy. When they were re-evaluated, the point system suggested that they would not be cured. The total chemistries which were good in the beginning went way down. The function and volume determinations between the two kidneys went way down. So if you think you have a patient with this disease, do something about it as soon as possible.

As far as the scoring system goes, Dr. Winter has used it in some 27 patients, and it has worked as far as prediction is concerned in all. We have done it with 21 now and it has worked in all but one of those patients.

Now let us return to the patient presented today. I cannot plot him out completely, but his age is good. The duration is important to know, but the factor against him is his total renal function as manifested by the elevated BUN and creatinine. Were this man to have nephrectomy he would not be cured. Split function tests would have been helpful, but had they been able to get a catheter up I suspect there would be no function on the affected side. The intravenous pyelogram is against him. The aortogram shows no filling of the involved kidney and suggests to me disease on the other side. I do not think he would be cured by nephrectomy. What I would do surgically would be to look at both arteries and consider doing an endarterectomy on the left side. If there was only a shrunken kidney on the left, I would take it out and consider endarterectomy on the other side. The affected kidney frequently is the better kidney and the contralateral normal kidney is the one with arteriolar lesions secondary to the impaired kidney. Leaving this in propagates the hypertensive process.

Dr. Freeark: I take it from the expressions on several members of the audience that we

should clarify one extremely important point. The effect of ischemia on one kidney causes it to produce a circulating substance which in turn acts upon both kidneys. However, the deleterious effects of the circulating pressor substance is greater on the nonischemic or "good" kidney since it has a normal blood supply. Is there any knowledge as to what this pressor substance is? Is there evidence that it differs in the ischemic kidney as opposed to the diseased kidney of pyelonephritis, for instance? Are these similar mechanisms?

Dr. O'Conor: These compounds, "Hypertensin I and II," are primarily the result of renal ischemia, but in the contracted, chronic pyelonephritic kidney there are arteriolar changes that probably result in production of the same substance. The important thing is that the diseased or ischemic kidney produces an increased amount of renin which acts upon hypertensinogen to produce active pressor substance hypertension which affects the contralateral kidney. Cells of the ischemic kidney remain unchanged. Patients who die of this disease often have a normal-looking kidney on the bad side, and the good one is the site of extensive pathologic alterations.

Dr. Freeark: I would like to re-emphasize once again the significance of the enlarged renal artery seen on the right in this patient. It is a frequent occurrence to see a vessel enlarge distal to the point of narrowing. Such an enlarged artery does not mean that the blood supply is improved or is adequate, but it suggests poststenotic involvement and may reflect serious reductions in total flow through the vessel. Exploration of this patient was undertaken with several considerations in mind which might serve to forestall the inevitable course of his disease. We thought he had an abdominal aortic aneurysm which, in a fellow with borderline uremia, is unlikely to kill him before his uremia does. We thought we would explore the status of the left renal vessels and were optimistic enough to think that either removal of that kidney or a procedure designed to restore its circulation might reverse or stablize his uremic state.

At surgery a diffuse aneurysmal dilatation of the entire aorta from the bifurcation well up into the thorax was identified and considered unresectable in the light of his general condition. The right kidney was of normal size, but the left kidney was small—about one-third the size of the right. The left renal artery was dissected free and found to be very small and narrow throughout its entire length. The small adrenal arterial vessels seemed to be supplying some flow to this kidney, but there was no flow detected on needle aspiration of the proximal artery. Reparative arterial surgery was precluded by the small size of this vessel. Because we were postulating that some benefit might be achieved by removal of this nonfunctioning kidney, it was elected to perform nephrectomy which Dr. McEnery accomplished without difficulty.

The renal artery was ligated near its origin from the aorta, and inspection of the distal vessel revealed marked narrowing which appeared to result from fibrous intimal proliferation. Although other vessels in the abdomen revealed findings of generalized arteriosclerosis, the stenotic renal artery was soft, pliable, and of normal external appearance except for its size.

Shortly after nephrectomy, the patient experienced a cardiac arrest which was promptly corrected by closed chest massage before thoracotomy was attempted. After this experience we abandoned all attempts to investigate the right renal artery. The right kidney was palpably normal, but I cannot exclude your suggestion that there is a plaque-like situation at its origin which might have been a more fruitful area to repair. Dr. O'Conor has questioned the wisdom of nephrectomy. I doubt very much whether restoration could have been achieved by any of the vascular techniques described because of the small size of the renal vessels on the left. I suspect it was an end-stage problem for which there was little solution. Following nephrectomy and cardiac arrest, he had a stormy convalescence but did recover. He was returned to the medical service after three weeks, and there has been no significant change in either his blood pressure or blood chemistries. Apparently the removed kidney was contributing little to his total renal function, and its hypertensive effect on the good kidney was now irreversible.

Dr. O'Conor: I think the operation was justified under the circumstances. One should not look upon cases like this as completely hopeless. You may not cure their hypertension but occasionally you can improve renal function. We have operated upon several people with markedly reduced renal function and with malignant hypertension, and by doing an endarterectomy have improved renal function but have not changed the hypertension. So this is another potential, though now an uncommon indication for operating upon some of these people.

Dr. Daniel Kushner (director, medical education, Cook County Hospital): As one looks at the criteria you have emphasized, I am impressed that they include a large percentage of hypertensive patients we see at this hospital. They may be young or old, and they nearly all have progressive disease. We know that many internists look for years for a pheochromocytoma as the cause for hypertension and never find it, and we wonder if we shouldn't work from a different point of view such as the one described today. Yet, how far should we go in these studies? We know that a normal pyelogram does not exclude a vascular abnormality. We have not been satisfied with split function tests, and we have not as yet evaluated the new approach utilizing the sodium-to-creatinine ratio. Therefore, we are constantly concerned about which patients to subject to angiography.

Dr. O'Conor: I would say that you would be far better off taking the time, effort, and money that you spend in ruling out pheochromocytoma and do radioisotope renograms. At least 2 per cent of all hypertensives are said to have renovascular disease. The isotope renogram is a good, safe screening procedure; and if that is abnormal and the intravenous pyelogram is abnormal, further study is definitely indicated. When you obtain a normal renogram and normal intravenous pyelogram, you would probably be better off avoiding aortography.

Dr. Freeark: The split function test involves retrograde catheterization and considerable laboratory study. They are inconvenient, introduce a risk of infection, expensive, and are difficult to perform accurately. In some cases as in the patient presented, you are unable to get a catheter up both ureters. The renogram is available in any case.

Question: Is there any method for determining whether the contralateral kidney has been affected by the ischemic process?

Dr. O'Conor: On a split function test, if the contralateral kidney is affected, the differential function betwen the two becomes less. All of our tests are in a sense comparative studies. Of course, renal biopsy would be ideal, but just try to sell somebody on biopsy of the contralateral kidney.

Dr. Freeark: The pathology of the removed kidney in this patient was interesting. On histologic study it showed evidence of chronic pyelonephritis and nephrosclerosis. It was a very small kidney, weighing 60 Gm., and there was stenotic involvement of the renal artery.

Dr. O'Conor: For many years, there has been a tendency to label all small kidneys as chronic pyelonephritis, and we often are required to sign cases out this way. Our concepts, however, are changing. The fact that the kidney shows fibrosis and lymphocytic infiltration fits in with Dr. Paul Szanto's study at this institution showing that these changes can be the result of arteriolar disease; and on going back over the cases operated upon, most of them have been signed out as chronic pyelonephritis, but that is really not the disease. I think it is surprising that this man had so few white cells in the urine. Many of these people do have lymphocytic infiltration and are signed out as chronic pyelonephritis.

Dr. Freeark: Dr. O'Conor, we thank you for this very informative and beautifully presented discussion. We enjoyed it very much.

Summary and Conclusions

1. Although less than 5 per cent of patients with hypertension can be accounted for on the basis of primary renal disease, the opportunities for permanent and complete control of blood pressure through surgery offer a real diagnostic and therapeutic challenge.

2. Such cases may result from disease processes of the *renal parenchyma,*—e.g., glomerulonephritis, pyelonephritis, congenital polycystic kidneys—or *disturbances of the renal vascular supply* which render all or part of kidney ischemic, e.g., renal artery atherosclerosis, embolus, or aneurysm. It is important to remember that long-standing hypertension from any cause exerts a deleterious effect upon the kidney and that such a kidney may secondarliy become a factor in perpetuating hypertension.
3. The significant features leading one to suspect a *renal* cause for hypertension are:
   a) Onset at a young age (below 30)
   b) Onset at an old age (over 55)
   c) Abrupt onset or abrupt change in a long-standing hypertension
   d) Rapid progression of hypertension characterized by eye ground changes, epistaxis, headaches, anorexia, and heart failure
   e) Onset associated with an episode of flank or abdomnial pain (renal infarct)
4. *Intravenous pyelography* should be carried out on all patients with hypertension and may give a clue to the existence of renal vascular disease. Significant x-ray findings may be:
   a) Abnormal renal contour—irregularity of outline may be the result of contraction of one pole or segment due to eschemia.
   b) Reduction in size of the kidney—1 to 2 cm. difference may be significant.
   c) Delay in concentration and appearance of contract media excreted by one kidney in comparison with the other.

   Any of the above with a perfectly *normal retrograde pyelogram* suggests renovascular disease.
5. Additional screening tests of value in the detection of renal hypertension or identification of the responsible kidney are comparative studies on the excretory function of the two kidneys simultaneously using ureteral catheters ("split function studies"), radioisotope renograms, and renal arteriography. Recourse to contrast visualization of the renal vessels is required for definitive diagnosis in most cases and should be performed in all patients undergoing definitive surgery.
6. Although many cases of renovascular hypertension may respond temporarily to antihypertensive drugs, most authorities favor surgical therapy, provided the patient's life expectancy and general condition are consistent with it.
7. The treatment may consist of nephrectomy, partial nephrectomy, or a reconstructive procedure on the renal artery. Selection of appropriate operative procedures requires knowledge of the status of the opposite kidney as well as careful assessment of the renal vascular pedicle.
8. Previous experiences with nephrectomy for unilateral renal disease causing hypertension indicate good results in less than 20 per cent of the cases. Recent efforts emphasizing earlier detection and renal revascularization give evidence of cure rates approaching 80 per cent.

Surgery for Bowel Obstruction

Diverticulitis is the most frequent cause of inflammatory obstruction of the colon, and by far the most common areas to become obstructed are the sigmoid and rectosigmoid. While the obstruction is usually not so acute as that due to carcinoma, the clinical differentiation may be quite difficult. When the obstruction is complicated by localized abscess, dissection must be done carefully to avoid spillage of abscess contents. Such inflammatory lesions may also involve small bowel obstruction by adhesion to the inflammatory area. In such cases we have found it best to separate the adhesions and to treat the diverticulitis by staged resection with subsequent closure of the double-barrelled colostomy. When the small intestine is not involved, we have found primary resection with immediate end-to-end anastomosis to be safe. Antibiotic drugs are given intravenously for 72 hours postoperatively. *Albert Behrend, M.D. Large Bowel Obstruction. Am. J. Gastroent. April 1961.*

Correlation of serum cholesterol levels and human atherosclerosis and its sequelae

J. C. Paterson, M.D., *London, Canada*

Now that the Central Committee of the American Heart Association has released a statement implicating high fat diets and high serum cholesterol levels in the production of atherosclerosis and of heart attacks and strokes,[1] the uninitiated physician or layman may be tempted to infer that the final word on this controversial subject has been spoken. Such an inference, however, seems to be unwarranted in the state of our present knowledge. In the first place, the A.H.A. statement is qualified by so many "if's" and "but's" that the careful reader might well ask what purpose was served by its release. Secondly, the final conclusions in the statement are based on what is described as "the best scientific evidence available at the present time"—a provocative remark, to say the least. Indeed, one wonders just how, in the welter of reports on human atherosclerosis, certain data were categorized "best" while others were relegated to an inferior position. In any event, the A.H.A. statement does not mention that evidence is at hand which throws strong doubt on a relationship between the level of serum cholesterol and the severity of atherosclerosis. The purpose of this paper is to bring this other evidence to the attention of the readers of the Journal.

Landé and Sperry in 1936 failed to show any relationship between the level of serum cholesterol and the amount of lipid in the aortas of persons dying suddenly and violently.[2] This evidence against the cholesterol theory, reported 25 years ago, seems to have been ignored, presumably because the cholesterol determinations were made on post-mortem blood. Landé and Sperry defended this particular technique, maintaining that post-mortem serum cholesterol estimations are valid provided that significant lesions of natural (chronic or wasting) disease are absent at autopsy—that is to say, that only cases of sudden and violent death are studied. Recently (and since the A.H.A. statement appeared), Mathur and associates have confirmed these claims in experiments carried out in India.[3] They failed to find any significant change in the post-mortem serum cholesterol level from the ante-mortem level, provided that autopsy is not delayed more than 16 hours. Furthermore, they brought forward strong evidence that the levels of post-mortem serum cholesterol are not related to the severity of atherosclerosis in individuals dying suddenly and violently.

Ante- and Post-mortem Study

Paterson and associates, in a long term project dating back to 1953, attacked the problem in a different way. They determined serum cholesterol levels at least once a year on a large number of permanently hospitalized male patients, mostly psychotics, each of whom was in reasonably good physical health until the onset of his terminal illness. During their stay in the hospital, the patients were offered a diet yielding 2,500 to 3,000 calories per day, of which 25 to 30 per cent were derived from fat. When

From Westminster Hospital and the Collip Medical Research Laboratory, University of Western Ontario.

While the Nutrition Committee of the Chicago Heart Association is sponsoring this article, the opinions expressed are those of the authors and do not necessarily represent the official view of that committee.

a patient died and an autopsy was performed, the severity of atherosclerosis was estimated in four different arteries (including the coronary and cerebral arteries), by using six different criteria. The presence or absence of the pathologic sequelae of coronary and cerebral sclerosis was also noted in each case. The final stage in the procedure was to compare directly the mean ante-mortem serum cholesterol level in each individual with the severity of atherosclerosis post-mortem in his arteries. The last report on this long term project,[4] published in 1960, consisted of a statistical analysis of the data from 58 fatalities in the age group 60-69 years. The results offered little support to the contention that the severity of atherosclerosis is related to the level of serum cholesterol, except perhaps when it exceeded 300 mg. per 100 ml. Significant relationships were found only once in 40 separate statistical analyses, and the complications of coronary and cerebral sclerosis (heart attacks and strokes) were found just as frequently in persons with low serum cholesterol levels (150-199 mg. %) as in persons with moderately high levels (250-299 mg. %). Since this last report was published, the data have been re-evaluated, using only those cases that did not show excessive weight loss terminally. The results of this later analysis, particularly those pertaining to coronary arteries, were essentially the same as the results in the larger series.

Conclusion

It is obvious that the data obtained in these three studies are directly opposed to those quoted by the writers of the A.H.A. statement. The reason for the discrepancy is also fairly clear. The A.H.A. statement was based on certain selected studies in which the levels of serum cholesterol were compared in persons who had, or did not have, clinical signs or symptoms of coronary or cerebral atherosclerosis. On the other hand, the three studies summarized here were concerned with comparisons between the serum cholesterol levels and the extent of arterial disease found either at autopsy or on biochemical examination of arterial tissues.

Which is the more reliable technique? Opinions on this differ, but on one point there is no controversy: Asymptomatic coronary or cerebral atherosclerosis is now known to be extremely common. Thus, because a man has no clinical signs or symptoms of coronary or cerebral artery disease, there is no assurance that he does not harbor moderate or severe grades of atherosclerosis in these vessels. With this in mind, and assuming of course that atherosclerosis is the usual primary lesion in arterial occlusion, it is left to the reader to decide whether a true verdict has been reached in implicating high serum cholesterol levels in the causation of heart attacks and strokes.

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Postgastrectomy Anemia

The reports on the incidence of anemia in postgastrectomy patients vary considerably. Rumball and Hassett, on reviewing the literature, found the incidence to range from 0 to 44 per cent. Their considered conclusion was that if a careful evaluation is made of each gastrectomy patient, hypochromic anemia would be discovered in a significant number. That iron deficiency is a common sequel to subtotal gastrectomy was further supported by their finding of low or borderline iron content of the serum of one-third of the patients studied. There is some evidence that this is the result of malabsorption of iron due to bypassing of the duodenum where iron is chiefly taken up from the intestinal tract and to the failure of the partially resected stomach to reduce iron compounds from the ferric to the ferrous state. *Everett D. Kiefer, M.D. Postgastrectomy Syndromes. Am. J. Gastroent. April 1961.*

The View Box

FRANZ GAMPL, M.D., *Chicago*

This 18 year old Negro boy came to the orthopedic clinic with dull aching pain in his left lower leg and knee. The pain first appeared after he had struck his knee against a tractor 6 months previously. The pain had become more severe, was aggravated by motion, and kept him awake at night. He denied any chills or fever.

On physical examination there was slight atrophy of the left thigh and the calf, both of which measured one inch less in circumference than the right leg at corresponding points. A bony, hard tumor, moderately tender on palpation, was felt at the medial aspect of the left upper tibia.

Two radiographs of this area were obtained.

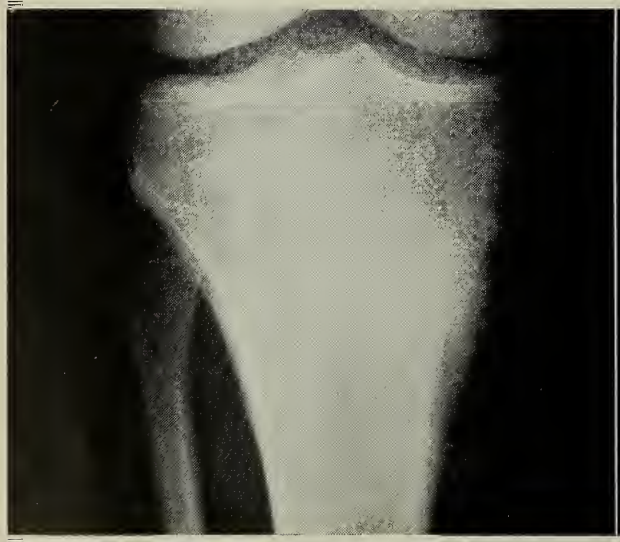


FIGURE 1. Anterior-posterior view

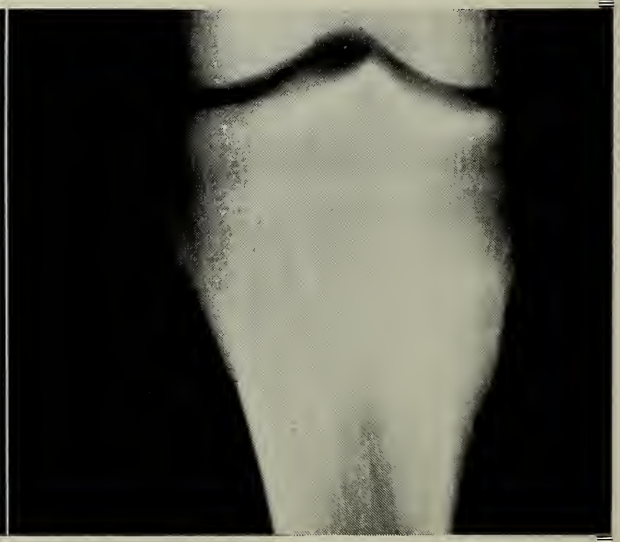


FIGURE 2. Laminographic study of the same area

What is your diagnosis?

(1) Chronic osteomyelitis

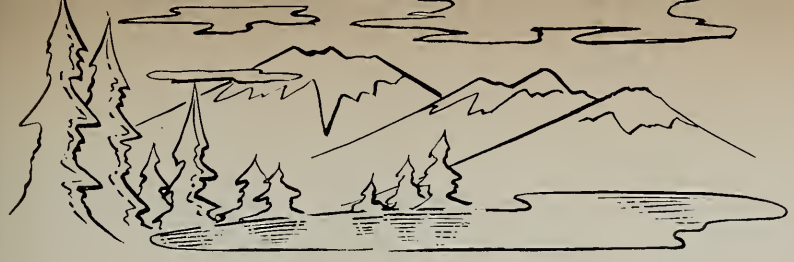
(2) Brodie's abscess

(3) Early osteogenic sarcoma

(4) Osteoid osteoma

(continued on page 241)

From the radiology department, Cook County Hospital



MEDICINE in the OUT-OF-DOORS

Vision in the Hunter and Hunted

Julius M. Kowalski, M.D., *Princeton*

Followers of goddess Diana possess reasonably compensated vision or they would have departed from this cult as neophytes. The importance of this special sense to their sport they recognize, but the many intricacies of sight for them remain unknown. Motivated by atavistic instincts, they endure hardships and self-denials requisite to the hunt which border on masochism, for only by undaunted perseverance will they occasionally strike the target. And more often than not the anticipation, preparation, and quest are more meaningful than the trophy.

Visual acuity—the resolving power of the eye—is dependent upon retinal functions such as sensitivity to light and the ability to distinguish closely approximated parallel lines as being separated. When acuity is normal, form, outline, and minute details of our surroundings can be properly interpreted if neurologic and psychologic abnormalities are absent.

Though every hunter is aware that he must have "keen" eyes, just how much visual deficit is permissible? There is no uniform answer to this since only a few states require an examination, and that the most rudimentary, and the majority give none. But it is reasonable to expect that a person in the field with a lethal weapon should meet the minimum standards of a motor vehicle licensee as approved by the American Medical Association some years ago —visual acuity, with or without glasses, of 20/40 in one eye and 20/100 in the other. Should testing of hunters become general practice, and this is a moot question, a comparable situation might develop as occurred in a Midwestern state where some 600 recipients of state aid for blindness objected strenuously when their driving licenses were revoked for substandard vision. Since the diurnal movement and feeding of most wildlife occurs in the twilight of dawn and dusk and visual acuity lessens with decreased illumination, it is essential that minimum requirements be met.

Although the art of shooting is a complex function, "sighting" in the conventional manner is not necessary for quick-draw or instinctive shooting at close range. Witness the barroom Sally as she gets her two-timing Joe. Present-day quick-draw champions can draw, fire, and score a hit in less than 1/16th of a second. Should one blink his eyes at the beginning of this action, he would never witness it since normal psychologic blinking consumes this time interval.

The subject of the dominant or master eye is often raised by those newly interested in shooting. They may not know it, but the problem has been resolved, in all probability, after a few trials. Left eye dominance for a man shooting from the right shoulder will result in gross misses and require much training. Most right-handed individuals are right eyed, and the converse is true. A simple test for eye dominance follows: Keeping both eyes open, look a a distant object—a light switch

or other small object on the opposite wall. Now point at this object with the index finger of the right hand. Close the left eye. The finger and object will be in alignment or nearly so if the right eye is dominant. It may be necessary to repeat the test a number of times for conclusive evidence. To have the value of binocular vision, a gunner should always keep both eyes open; this holds for hand gun, rifle, and shotgun.

Another important quality for target identification afield is color vision. About 8 per cent of males and 0.4 per cent of females have color perception defects. Red-green blindness is most common. Discrimination between these two colors is not possible, and they appear as tones of gray to the afflicted. Blue-yellow blindness is rare, and these appear as the same color. For years it was assumed that because red is usually associated with danger it would be the safest color to wear in the woods for hunters' protection. Many had misgivings about its efficacy, but it was a part of almost every state hunting code and these statutes, until recently, were known for their static inertia.

Under autumnal field conditions of haze, fog, rain, and snow in the feeble light of dawn and dusk the conventional red hunting coat was often imperceptible from the surroundings. In 1956 California researchers found that yellow was more easily identified than red under field conditions. This finding aroused curiosity in other quarters if for no other reason than to contribute to the iconoclastic debacle on red. A number of Massachusetts state agencies in cooperation with U.S. Army personnel from Fort Devens in 1959 tabulated thousands of sightings of various colors under field conditions in Massachusetts during October and November of that year and January of 1960. These findings proved decisively that two fluorescent colors with the trade names of Neon Red and Blaze Orange were identified unmistakably by men with normal and aberrant color vision and that hunting garments in these colors should be better than any seen in the field heretofore.

Color and form deception—camouflage—has come into regular use in recent years, especially by bow hunters and those primarily engaged in calling or stalking game. Combat units in World War II used camouflage to excellent advantage in various theaters of operations. Many novices fail to appreciate how one's face and hands stand out against natural background. Unless one is well concealed, it is best to wear netting over the face and glove the hands, even in mild weather.

Injuries to the eyes from slapping foliage, twigs, rushes, wind-borne foreign bodies, and occasionally shell debris are not uncommon in the field. The wearing of shooting glasses is highly recommended; their seemingly high initial cost is more than offset by the protection they afford, often the difference between severe and mild injury. A spent shotgun pellet can produce serious injury to the eye, whereas shatterproof glasses could prevent this. They ease eye strain—green or smoked glass for bright sunlight, yellow for overcast days—and in the opinion of many hunters help sharpen outlines. For those approaching the presbyopic age of 43 to 46, it is a great convenience to have lenses corrected for near vision. Loss of accommodations is a hard-to-accept reality and is frequently the first inkling that youth has waned and a man isn't as good as he used to be. Vitamin A will not improve poor vision. It is better to eat well-balanced meals regularly and in moderation.

The quarry, too, has keen vision; anything less would result in extinction. The ubiquitous rabbit has been around for 40 million years. Peripheral vision and the perception of movement are the forte of all game and birds. Color vision in mammals is absent or only poorly developed, but the slightest unnatural movement will at best momentarily hold their attention or, more likely, send them scurrying—especially deer, elk, and antelope. Mountain sheep possess keen vision. Bears are myopic. Of the birds, the eagles, hawks, turkey, ducks, and geese perceive color, and the predatory birds have the keenest vision, far surpassing that of man. After spending fruitless hours in the blind, when seemingly all precautions have been taken, one need only police the area to find that colored hulls, white lunch papers, or other man-made debris were flaring the ducks.

Sharp sights, clean hits, or complete misses.

The View Box-diagnosis and discussion (*continued from page* 238)

The preoperative diagnosis of osteoid osteoma was confirmed by the histopathologic report of the surgical specimen.

The typical radiographic finding is a radiolucent nidus surrounded by an area of reactive bone sclerosis (Fig. 2). The nidus may or may not contain a calcified core. These findings, if demonstrable, are pathognomonic. Special radiographic technics (Bucky radiography and laminography) are extremely helpful in demonstrating a small nidus within a large area of bone sclerosis.

Histologically, the nidus consists of osteoid trabeculae embedded in highly vascularized connective tissue. The surrounding soft tissue may show some nonspecific inflammatory changes.

The pathogenesis of osteoid osteoma is not known, but most investigators agree with Jaffee that the lesion is a true benign neoplasm rather than an infectious process.

The tumor may be found in the long tubular bones of adolescent patients but may also occur in the cancellous structures of the vertebral column, pelvis, and the ribs. Dull aching pain, often relieved by salicylates and more severe at rest, is suggestive of the diagnosis. Absence of signs of infection at the site of involvement and absence of systemic symptoms also point to the neoplastic nature of the process.

Biopsy with removal of the nidus or en-bloc resection of the entire area will result in permanent cure; it will also exclude the possibility of an osteogenic sarcoma in atypical cases.

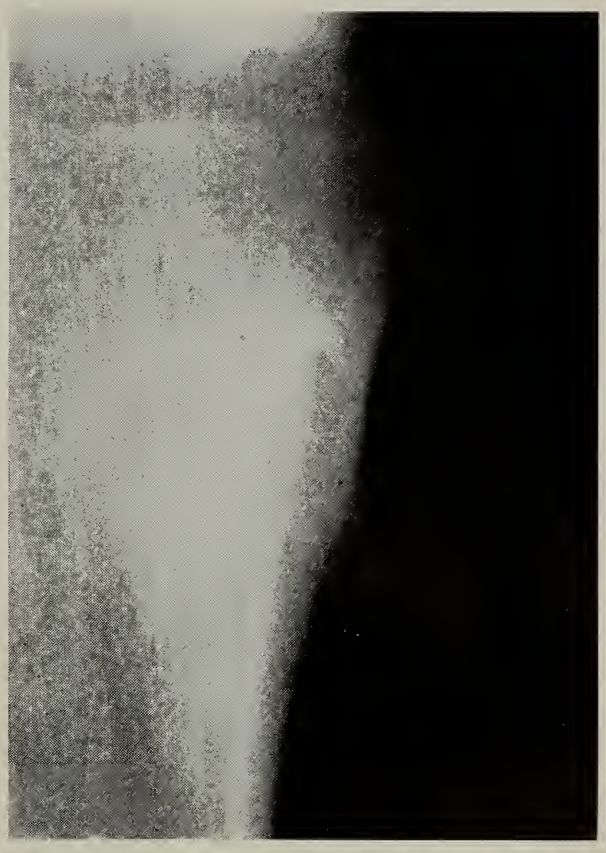


FIGURE 3. An enlargement of figure 2 showing the radiolucent nidus with the central calcification.

Further Reading

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The Physician Within

The truth is that every human being has nothing whatsoever to rely upon except what he can accomplish by means of his own life. Everything in his mind is the creation of his life process; it is himself. He uses his mind as an instrument for developing his medical self-experience which will promote his maintenance, or recovery, of his optimal health. Paracelsus held every man to be his own doctor, claiming, "The physician is in ourselves, in our own nature are all things that we need." His treatment of wounds was "defensive so that no contingency from without could hinder Nature in her work." And Sir Thomas Browne saw his medical self, "Things cannot get out of their natures, or be or not be in despite of their constitutions." *John M. Dorsey, M.D. Vis Medicatrix Naturae. J. Michigan M. Soc. Jan. 1961.*

Otitic Meningitis —A case report

Peter Oppenheimer, M.D.,*

and Kishin Gandhi, M.D.,** *Chicago*

"The marvelous reduction in the frequency of otitic complications and the markedly improved prognosis of the intracranial complications has been accompanied perhaps inevitably by a less fortunate tendency to forget the importance of the middle ear in cases of brain abscess, sepsis, and nonmeningococcal meningitis. The family physician has come to rely more on drugs to take care of ear infections than upon careful clinical study and early otologic consultation. The diagnostic acumen of the otologist has been blunted by his diminished experience and lessened familiarity of otitic complications. The situation has been made more difficult by the masking effect of antibiotics on the symptoms of continued infections. These factors may be resulting in a recent increase in serious complications of otitis media, particularly in proportion to the number of cases of surgical mastoiditis."[1]

Case Report

A 13 year old Negro girl whose ears drained intermittently since early childhood was seen in our outpatient clinic a few weeks prior to hospital admission. Initial examination showed a central perforation of the left eardrum and the external canal filled with a purulent exudate. Hearing was decreased in the ear also. The patient was put on ephedrine nose drops and polymixin B sulfate (Cortisporin®) ear drops and told to keep the ear dry. She was seen once subsequently. The patient was unchanged, and she did not return for subsequent visits. A few weeks later she was admitted to the contagious disease hospital with the diagnosis of meningitis, possibly of otitic origin.

According to the mother, the patient had been having mild chills, fever, and back and neck pain for 10 days. The family physician gave her three or four penicillin shots. Two days prior to admission the patient became irritable and lethargic. She ached "all over" and developed violent chills and fever. The mother then brought her to the hospital.

Examination revealed positive Kernig's and Brudzinski's signs, temperature 103 F., blood pressure 100/80 mm. Hg, cloudy sensorium, slight cerebellar signs, and a profusely draining left ear. Sinus and chest films were negative. The eardrum had a central perforation 2 mm. in diameter near the umbo, and there was slight fullness and tenderness over the mastoid. A specimen was taken for culture and sensitivity tests. Blood culture and nasopharyngeal smears also were taken, and a spinal tap was done. The pressure of the fluid was 300 mm. It was cloudy, and the cell count was 700 (polymorphonuclear leukocytes) and the Pandy test was strongly positive. No bacteria were found. Cultures from ear, blood, and cerebrospinal fluid were all sterile. The nasopharynx showed no pathogens. Because of inability to find a focus of

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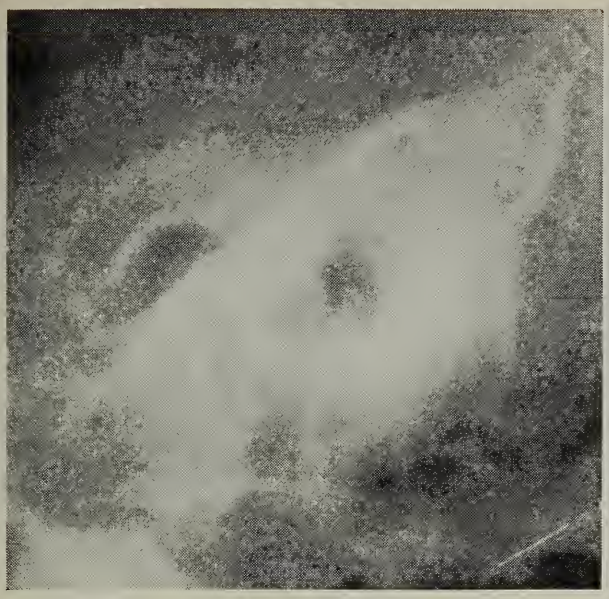


FIGURE 1. X-ray showed a sclerotic mastoid with intact tegmen and "no evidence of cholesteatoma."

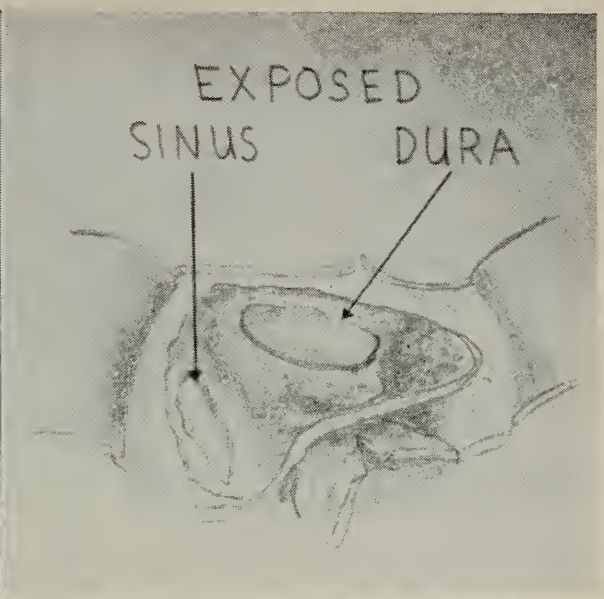


FIGURE 2. The cholesteatoma had eroded the tegmen and dural plate.

infection other than the ear, it was decided to explore the ear surgically. Mastoid films (Fig. 1) showed a diploic mastoid but intact tegmen and "no evidence of cholesteatoma." Impression: possible coalescent mastoiditis.

Under endotracheal anesthesia a postaural incision was made, the ear pushed forward, and an antrotomy performed. A cholesteatoma filled the antrum. The antrotomy was extended to the attic and revealed that the cholesteatoma filled the entire mastoid cavity. It had eroded the tegmen and sinus plate (Fig. 2). The dura looked pink and healthy, and needling the sinus revealed "free flow" of blood. The head of the malleus and all of the incus were gone. The cholesteatoma did not extend into the middle ear. A Bandy modified radical mastoidectomy was performed.

Twelve million units of penicillin were given intravenously along with streptomycin (1 Gm. daily). The next day sulfisoxazole (Gantrisin®) was added but was discontinued two days later along with the streptomycin, because of service changes. Kanamycin (1 Gm. daily) was started. Penicillin and kanamycin were continued for ten days during which repeated spinal, blood, and ear cultures were negative.

The patient developed right side hemiplegia and right Jacksonian convulsions two weeks postoperatively. A diagnosis of brain abscess was made, but none was found during an exploratory operation. The neurologic signs almost disappeared two weeks later, but the elevation in spinal fluid pressure persisted, even though the cells and protein became normal.

The patient's sensorium gradually cleared, but a temperature of 102 to 105 F. was present in the morning and evening. Another search for an abscess was undertaken because of transient blindness and the continued elevation of spinal pressure.

To date, seven months after her admission to the hospital, the patient has a dry cavity, is afebrile, lethargic, has no localizing neurologic signs; spinal fluid is clear, and spinal pressure is 300 mm. It is the opinion of the neurosurgical service that she has a communicating hydrocephalus secondary to a purulent leptomeningitis of otitic origin.

Discussion and Conclusion

Meningitis continues to be the most common and dreaded intracranial complication of otitis media even in those cases that seem to respond to therapy. It accounted for 18 to 23 deaths (78%) due to otitis media in the antibiotic era as compared to 68 per cent in the preantibiotic era (85 to 124 cases).[2]

Most commonly meningitis is caused by a bone eroding process in the middle ear, i.e.,

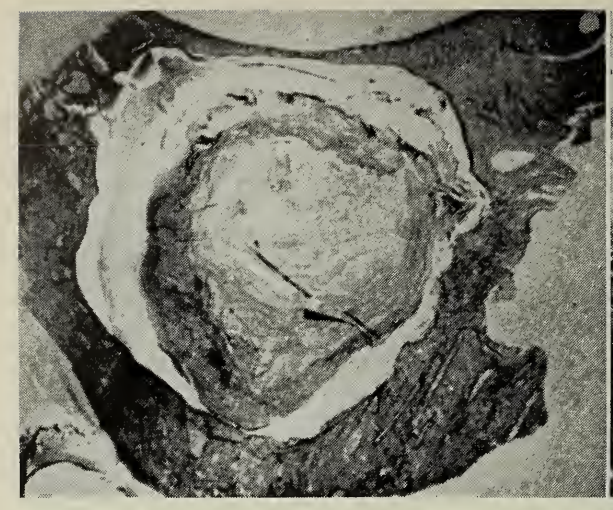


FIGURE 3. Otitis media with pus eroding bony walls.

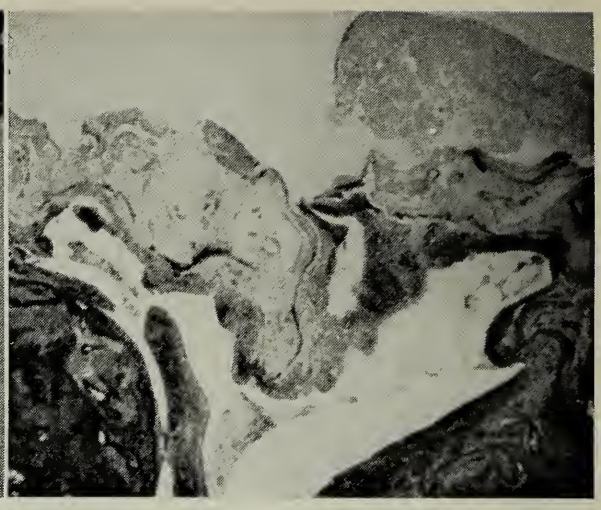


FIGURE 4. Cholesteatoma eroding tegmen.

Photos 2, 3, 4 from Lederer, F., M.D., Diseases of the Nose and Throat. Philadelphia, F. A. Davis Co., 1953, reprinted by permission.

chronic or acute otitis media with pus (Fig. 3) or a cholesteatoma, as in this case (Fig. 4), eroding the walls of the ear cavity. It is a complication that occurs late in the course of the disease with prodromal signs of impending intracranial involvement. The treatment is that of the complication and the surgical eradication of the "seeding" focus of infection in the middle ear.[1]

Two types of meningitis may ensue, localized or circumscript and purulent leptomeningitis or "frank" meningitis. Localized meningitis is near the seat of suppurative focus and is identified by signs of meningeal irritation with sterile spinal fluid. The diagnosis of each, of course, depends upon the spinal fluid.

This case illustrates several important points. Every case of acute and chronic otitis media has the potentiality to extend to an otogenic complication. A patient with a chronic otitis media sits on a powder keg as far as potential intracranial complications are concerned.[2]

The outlook is better when therapy is instituted as soon as possible. The random shifting from one antibiotic to another on a trial-and-error basis is to be condemned.[3] Though the antibiotics will check the majority of infections, they should be used properly, i.e., the appropriate drug in correct amount and duration after the offending organism has ben isolated. "Shotgun therapy" will lead to therapeutic disappointments. The clinician should be aware that intracranial extensions of otitic disease, however rare, do exist; he should be constantly alert for the first signs of such complications.

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Just Turn Him Over

The relative incidence of napkin rash, excoriation of the skin by scratching, and of crying was studied in a controlled experiment in which infants were chosen in rotation to sleep in the prone and supine positions. There was twice as much crying in the supine position, with more napkin rashes and more skin excoriations. When the position of the infants who were crying was reversed, one half of the infants on their backs stopped crying when placed in the prone whereas only an occasional infant crying in the prone position stopped crying when placed on his back. Of 141 infants in the prone position, two had chafing of the skin of the knees, and, of 140 on the back, two had chafing of the skin of the heels. *Prone or Supine? Brit. M. J. May 6, 1961.*

Treatment of Recurrent Mental Depression with Imipramine

Alex J. Arieff, M.D., John Adams, M.D., and James Crawford, M.D., *Chicago*

The purpose of this report is to record our results using imipramine* on patients with recurrent mental depression who had been followed in previous attacks, had not responded to drug therapy, and required electroconvulsive therapy.

Despite a vast amount of research on the cause of mental depression, we do not understand its etiology. There is no known basic cause. We do not have a specific treatment until this information is obtained.

There are many drugs that make people feel better. Some drugs simply stimulate the individual to make him feel better. Stimulants help people who are mentally depressed; and it is true also that depressive drugs, such as opium and alcohol, including the martini, cause mentally-depressed individuals to feel better during the period of time the drug is active. However, the after-effects often cause more depression. After reading many reports, one gets the impression that clinicians do not know their patients adequately because they have not followed them over a sufficiently long period of time. This makes it very difficult, even with blind tests, to do controlled experimental work. Also, one must understand that, on a percentage basis, when a good antidepressant drug is used, some patients may be lost in a series of a large number of cases in which the results may be under 60 per cent—60 per cent being taken as almost placebo level. Again, a particular drug may be beneficial for a particular patient in an attack of mental depression, only to be found ineffective in a second or third attack in the same patient. The senior author has personally observed this phenomenon with drugs such as opium and Dexedrine®.

Much has been written about the pharmacology and physiology as well as the clinical use of imipramine. Thousands of patients have been treated with this drug with varying success. A comprehensive report[1] on its use came from McGill University. For those interested, we would advise perusal of this volume.

It is of interest that imipramine, one of the newest antidepressive agents, is similar to but differs from promazine. It is not an amine oxidase inhibitor and does not act as a stimulant, which is in contrast to amphetamine-like drugs and methylphenidate (Ritalin®). Its action as an antidepressant is unknown despite many theories on the subject. In general, up to 75 or 80 per cent of patients have responded favorably. One of the favorable actions of imipramine is that it is usually effective within a period of about a week. The drug is not likely to be effective if the length of time is longer than this.

Results and Clinical Case Reports

We have obtained 50 per cent remissions in over 100 patients having various types of depressions—some schizoaffective, most of them recurrent, and some classical manic-depressives. Some of these have been quite remarkable in a short period of time, i.e., in days and

*Tofranil. Aided by a grant from Geigy Pharmaceuticals

From the department of neurology and psychiatry, Northwestern University Medical School and the neuropsychiatric department, Passavant Memorial Hospital, Chicago.

usually not over a week. In some patients the addition of dextro-amphetamine was of definite benefit. At times, bromides or barbiturates were used in combination. We have had no severe side effects in contrast to other reports. Dryness of the mouth, disturbance in accommodation, mild tremor, excessive sweating, weight gain, and dizziness have been reported. Other side reactions, less common, are urinary frequency, nausea, vomiting, and skin eruptions. In one of our patients orthostatic hypotension was a definite complication, and the medication had to be stopped. There have been reports of lowering of the convulsive threshold in epilepsies and transient jaundice. Thus far, no habituation or addiction has been reported.

In this paper we have purposely not analyzed our results with respect to the various types of depression since we have not observed any correlation between the type of depression and the usefulness of the drug. It is for this reason that we feel the drug can be used in any type of mental depression, regardless of diagnosis. The following are clinical examples:

Patient No. 1, R.N., 69 year old female. This woman had been "sick all of my life," but managed to raise a family and had relatively little difficulty. Six years previously she developed a generalized infection followed by her first mental depression. Since 1955 she received seven courses of electroconvulsive therapy (ECT) for recurrent mental depression. Usually three to four treatments were sufficient to bring her into a remission. Drug therapy was unsuccessful. In September of 1959 she developed a mental deprssion following a gastrointestinal infection. She was placed on imipramine, 100 mg. daily, and within a week she improved. Remission was complete. Several months of follow-up confirmed that she was entirely well. She returned to her previous activities, and until June of 1960 she was quite active, lived alone, and took care of her own apartment. This was the first time medication had been effective in relieving her mental depression. At that time she began to lose pep. She complained that her arthritis was more bothersome. There was loss of appetite and weight. She had considerable difficulty in smiling, and she was again placed on imipramine, 100 mg. daily. In six weeks she was in complete remission. She returned to her household chores without developing arthritic complaints.

Patient No. 2, R.L., 70 year old female. This patient had a 50-year history of classical manic-depressive psychosis. She had been committed to state institutions many times. Electroconvulsive therapy had been effective in bringing her into remission except when she had a manic attack. In 1959, following an exacerbation of her diabetes, she developed a severe mental depression and was placed on imipramine by mouth, and 25 mg. three times daily intramuscularly. She showed no improvement over a period of weeks. Electroconvulsive therapy was again given. In January, 1960, the patient had another attack of mental depression and was again put on imipramine. This time she improved gradually and was discharged after three weeks. She remained in remission until June, 1960, when she began to show some minimal signs of depression. She was again given imipramine with definite beneficial effects.

Patient No. 3, A.R., 48 year old female. This patient had a neurotic personality with obsessive-compulsive complaints throughout most of her life. In the preceding ten years she had had recurrent schizoaffective psychosis, consisting manly of paranoiac symptoms and mental depression. More than one attack had been aborted by ECT and at times insulin shock therapy. In the intervals between attacks she did fairly well on psychotherapy. In May of 1959 the patient was started on imipramine, 75 mg. daily, orally, as an outpatient. Since that time she has been more amenable to reason; she has been calmer and has not bothered the senior author on the telephone. In addition, she has gone through family troubles without too much difficulty. She is no longer hostile to her family. On more than one occasion an attempt has been made to lower the dosage of medication or withdraw it completely. When this is done, her husband calls to learn why she is so disturbed and why medication has been withdrawn. As of July, 1960, the patient has been maintained on 50 to 75 mg. daily.

Patient No. 4, Y.M., 35 year old married female. This patient is one of five siblings, all of whom had psychotic episodes. Her father and mother are inadequate individuals. The patient

has had recurrent episodes of schizoaffective psychosis, manly schizophrenic in type, with strong delusional tendencies, halucinatory experiences, and at times, mental depression. She attempted suicide on several occasions and received insulin shock treatments and ECT periodically. The patient received a total of 23 insulin shock treatments, and following these she was put on imipramine, 100 mg. daily. Since her discharge from the hospital she has been less hostile and resentful and has more insight. When she becomes disturbed, her medication is increased and then decreased slowly. In addition, she does well on 5 mg. of dextro-amphetamine periodically in the morning, especially preceding her menstrual periods. She can continue as an outpatient on these two drugs; however, one should not imply or deduce from this that the patient is a normal individual. It can be said that her present state is improved over what it was in previous years.

Patient No. 5, F.S., 58 year old female. The patient's past history included angina and duodenal ulcer. She developed an extreme agitated mental depression after months of illness in which she was somatically preoccupied. She was put on 150 mg. of imipramine and 10 mg. of dextro-amphetamine daily. For a time she seemed to making a remission, only to slip back, and finally ECT had to be used. During hospitalization she had a mild exacerbation of her depression with agitation that was definitely kept under control with imipramine and dextro-amphetamine. The patient has been out of the hospital for one year now. Two mild episodes of depression were controlled with these two drugs.

Patient No. 6, 63 year old female. The patient had had depressive symptoms for two years. Psychotherapy over a long period of time had been attempted but without change in the basic picture. Eight tablets of Deprol® daily had had no effect except to provide relief from insomnia. On 75 mg. of imipramine she experienced increasing nervousness, became agitated, and weak. The drug was withdrawn. Her blood pressure had fallen from 180 systolic to 110 systolic. It was apparent that the patient had some idiosyncrasy to this drug manifesting itself in hypotension.

Patient No. 7, 49 year old female. The diagnosis here was acute involutional melancholia with suicidal tendencies. The patient was about 49 years old. She was put on imipramine, 100 mg. intramuscularly, daily, and quieted down immediately. She was still obsessed with delusional ideas and the feeling that everyone was dead and that she was going to be killed. Though her agitation was lessened, she continued to look depressed, and it was necessary to use ECT.

Patient No. 8, R.K., 55 year old male. This patient is a classic example of a manic-depressive individual. He holds a responsible position as a mining engineer. He has been followed by the senior author for at least ten years during which time he has received ECT periodically. During his last mental depression, the patient was given 150 mg. of imipramine daily and dextro-amphetamine intramuscularly, but without effect. This remission was terminated by electroconvulsive therapy.

Patient No. 9, H.N., 50 year old female. The patient's mother committed suicide; her father is a class manic-depressive. The patient herself has definite characteristics of a schizo-affective psychosis with depression. Usually she calms down with psychotherapy and sedatives. She received ECT on three occasions with beneficial effect. In one attack of acute schizo-affective psychosis with depression, 100 mg. of imipramine was without beneficial effect. She has since been followed over a period of months with psychotherapy plus Dartol®, and this combination seems to be more effective in her case.

Patient No. 10, S.A., 36 year old female. This patient has a long history of recurrent mental depression dating back to the age of 18 years. The initial symptom is usually discord in the family. One of her siblings committed suicide Environmental factors usually precipitate her depression. The patient attempted suicide on more than one occasion. Imipramine, 75 mg. daily along with psychotherapy usually relieves the depression.

Patient No. 11, J.A., 45 year old male. The patient has always been an obsessive-compulsive individual, being aided in this by his wife who has a similar type of personality. He has held one job for 23 years. His last attack was precipitated by a promotion that required him

to do a great deal of dictating. Since that time he has become obsessed with the errors he commits, even though some of his errors have been minor. In early September of 1959 he became disturbed and lost appetite and weight. He became panicky and stopped all social functions. He had the classic manifestations of acute mental depression with obsessive-compulsive symptoms. On 100 mg. of imipramine he went into a remission gradually over a period of about four or five weeks, following which medication was withdrawn.

Patient No. 12, E.G., 46 year old male. This patient had been an obsessive-compulsive, neurotic individual with swings of mood all of his life. He became acutely depressed and agitated in June of 1958. With intensive psychotherapy and dextro-amphetamine he seemed to improve over a period of weeks, but after several months of outpatient care he regressed and was again hospitalized; it became necessary to give him six ECT treatments. He was again followed as an outpatient, improved, and returned to his work. However, he still had a multiplicity of complaints. In March of 1959, because of an increasing severity of depression, he was given additional ECT on an outpatient basis. He again went into partial remission. On two occasions imipramine was prescribed, but he refused to take the medication, stating it made him "too dry" and that it was of no value. He improved gradually but remained a problem because of the multiplicity of his complaints and swings of mood. In July of 1960 he was persuaded to try imipramine once again. Results were good. He is not entirely well but is improved greatly on 50 to 75 mg. of imipramine in addition to about 10 mg. of dextro-amphetamine. At the present time, he is being seen only once or twice a month. It is necessary to give him psychotherapy in addition to drug therapy. This was true of many others.

In conclusion, it can be seen that there are many patients of various types who respond to imipramine who required electroconvulsive therapy before. In all cases of mental depression, regardless of type, a clinical trial is necessary until a specific etiology can be determined and a specific therapeutic program worked out.

Summary

Approximately 100 patients have been followed by our group through many attacks of mental depression. Most of them received electroconvulsive therapy prior to the use of imipramine. In approximately 50 per cent a definite remission occurred when this drug was given. In some patients the addition of dextro-amphetamine, barbiturate, or bromide was necessary. Severe side effects were not noted.

It is our feeling that imipramine is a definite aid in the treatment of mental depression. This does not ignore the fact that other drugs are still helpful and that diagnosis as well as psychotherapy are of utmost importance.

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1. McGill University Conference on Depression and Allied States, Canad. Psychiat. A. J. 4:19 (Mar.) 1959.

Expansion of the Area Clinic

But how can all this help the problem of the outlying town where the old practitioner has retired or died and no young doctor can be attracted to take his place? Here is another situation which can be greatly helped by an over-all community-wide approach. In increasing numbers across the country, we find that groups usually located in the center of population of communities are establishing area clinics as the need or opportunity for replacement of older physicians arises. Functioning as an integral part of the group, these area clinics are attracting to outlying towns young, well-qualified physicians. The basic area clinic team of internist and pediatrician can be supplemented by regular weekly visits from the central office of a surgeon and obstetrician-gynecologist. Thus, a spectrum of medical, surgical, pediatric, obstetric, and gynecologic services can be very readily made available to even the outlying areas. In several communities, dentistry is being added to these services. *Caldwell B. Esselstyn, M.D. A Community Approach to Rural Medicine. J. Occupational Med. November 1960.*



Records of Tissue Committees and Research Projects Are Confidential

WALTER L. OBLINGER, *General Counsel*

WITH THE PASSAGE of S.B. #320 and its approval by the Governor on August 21, it is now expected that all information, interviews, reports, statements, memoranda or other data of in-hospital staff committees of accredited hospitals and of the Illinois Department of Public Health, the Illinois State Medical Society or allied societies, acquired in the course of medical study for the purpose of reducing morbidity or mortality, shall be afforded some measure of protection. A copy of the bill as amended is as follows:

"Section 1. All information, interviews, reports, statements, memoranda or other data of the Illinois Department of Public Health, Illinois State Medical Society, allied medical societies, or in-hospital staff committees of accredited hospitals, but not the original medical records pertaining to the patient, used in the course of medical study for the purpose of reducing morbidity or mortality shall be strictly confidential and shall be used only for medical research.

Section 2. Such information, records, reports, statements, notes, memoranda, or other data shall not be admissible as evidence in any action of any kind in any court or before any tribunal, board, agency or person.

Section 3. The furnishing of such information in the course of a research project to the Illinois Department of Public Health, Illinois State Medical Society, allied medical societies or to in-hospital staff committees or their authorized representatives, shall not subject any person, hospital, sanitarium, nursing or rest home or any such agency to any action for damages or other relief.

Section 4. No patient, patient's relatives, or patient's friends named in any medical study, shall be interviewed for the purpose of such study unless consent of the attending physician and surgeon is first obtained.

Section 5. The disclosure of any information, records, reports, statements, notes, memoranda, or other data obtained in any such medical study except that necessary for the purpose of the specific study is unlawful, and any person convicted of violating any of the provisions of this Act is guilty of a misdemeanor."

The Illinois State Medical Society has had some difficulty in obtaining information needed in connection with its research projects. Recently, a research project in Illinois, sponsored jointly by the Society and an eastern university, into the incidence of injury caused by automobile design, ran into some difficulty when some physicians indicated their reluctance to furnish the information requested on the ground that the record might be subject to subpoena. The physicians had been asked to comment upon the causal connection of the injury. Some

committees of the Society have indicated their reluctance to give factual reports on mortality studies or to evaluate results of these studies for the guidance of the profession. But by far the greater problem has been related to the operation of tissue committees in hospitals.

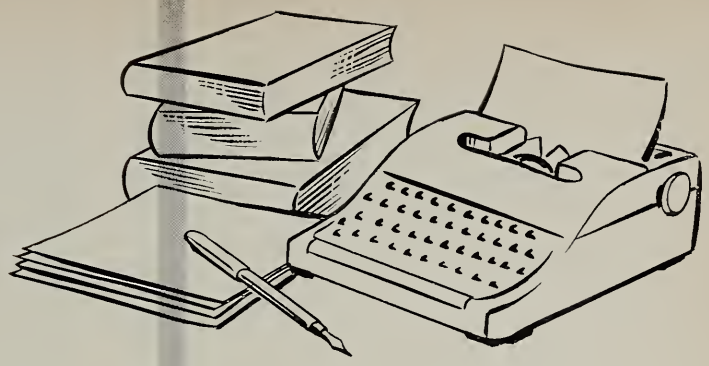
The Joint Commission on Accreditation of Hospitals, as an incident to accreditation, has adopted a rule requiring hospitals to set up tissue and maternal welfare committees. It is recognized that the proper operation of such committees can do much to raise the standards of medical care in the community. The difficulty has come when records are subpoenaed into court, particularly in malpractice cases, to establish the want of due care on the part of the physician. For this reason, many in-hospital tissue committees have not been keeping full and adequate records and, in many cases, no permanent records of any kind are kept at all. As a consequence, all of this vital experience is being lost for later reference and study. It is to protect these records that S.B. #320 was introduced.

The problem in connection with the keeping of records of tissue committees is one of standards and can be succinctly put as, the scientific standard of medical care versus the prevailing legal standard of medical care. For the purpose of proving malpractice liability, the law imposes a standard of medical care based upon the prevailing standard of medical care in the local community. In other words, the physician owes his patient a duty to render that quality of medical care such as can reasonably be expected from physicians practicing medicine in that community. The standard imposed by the tissue committees, on the other hand, is one of the highest and is designed to upgrade the prevailing standards of medical care and to impose medical knowledge upon the practitioners in that hospital such as may not be commonly possessed by medical practitioners generally. It is a vital, growing facet of medicine that should be encouraged. It might be likened somewhat to the ever-changing concepts of the common law. The growth of knowledge and spread of experience among local practitioners through this mechanism will now be protected and, it is hoped, stimulated by S.B. #320. Now it will be possible for these committees to keep full and adequate records, to make studies thereof, to release statistics and to properly index them for future reference.

In describing the activities of these tissue committees, Dr. Willard C. Scrivner of East St. Louis, in his testimony before the Senate Public Welfare Committee said, "These groups of physicians have neither legal status nor punitive authority. With the permission and cooperation of their fellow physicians, they seek to know, to learn, and to act in ways and by means to constantly improve the standard of medical care rendered. They seek to expose the careless, brand the incompetent, and point the finger at the dishonest. From such research data, it is unmistakably clear that there has not been a constant up-grading of care throughout. Some of the smaller hospitals not having the advantage of medical school affiliation have shown some of the greatest improvement. These committees are not content with the limits of legal medicine, but constantly seek the ideal in medical service through research. These Tissue Committees represent a voluntary effort in striving for better communication among all parties concerned."

It is to be hoped that S.B. #320 has now removed all fear of legal inquiry into the conduct of physicians judged by the scientific standard of medical care of tissue committees, and that these committees will now be able to keep adequate records and function properly in pursuit of the scientific ideal.

IT WOULD DO THE WORLD GOOD if every man in it would compel himself occasionally to be absolutely alone. Most of the world's progress has come out of such loneliness.—*Bruce Barton*



Editorials

Chromosomal abnormalities in man

The period prior to 1956 must be regarded as antediluvian in any consideration of the history of the development of our knowledge concerning the relation of gross abnormalities of chromosomes to disease in man. The development of the field was greatly stimulated by the discovery by Tjio and Levan in 1956 that the normal number of human chromosomes was 46 and not 48 as had been believed for the previous 30 years. Their fundamental discovery was made possible by the utilization of techniques developed for the study of chromosomes in other mammals. This illustrates again the frequent dependency of medicine upon advances in general biology for its own progress.

While it was at once evident from the work of Tjio and Levan that the pathway to the exploration of the morphology of human chromosomes in various disease states had been cleared, it was not known whether this would lead into a blind alley or onto a rugged road lined with previously unsuspected abnormalities. It seems curious five years later that, at the time, many qualified investigators believed that, with the possible exception of the sex chromosomes, gross abnormalities in the number and form of human chromosomes would prove incompatible with life.

With further technical advances, development was rapid. Methods for the suitable culture of bone marrow, certain solid tissues such as skin, and leukocytes derived from peripheral blood were developed. By treatment of the cells with colchicine or one of its derivatives to inhibit spindle formation, the regular accumulation of an adequate number of human cells in metaphase was accomplished. By use of a hypotonic solution these cells could be made to swell and disperse their chromosomes. After they were spread in the same optic plane by squashing or by drying in air, regular examination not only for chromosomal number but also for morphologic details of individual chromosomes became feasible. This was best accomplished by photographing suitable cells and enlarging the photographs to permit adequate study of chromosomal detail.

Confusion arose as investigators proposed various systems of nomenclature. Fortunately, in a summit conference held by cytogenetic investigators in Denver in 1960, a meeting which could serve as a model to politicians, the important differences were resolved, and a uniform standard system of nomenclature was agreed upon.[1] In order to define each chromosome, the length of the chromosome, the position of its centromere, and the presence of peculiar distinguishing features, such as satellites, were used. The acceptance of the Denver classification at a crucial point in the development of the field has greatly expedited investigation by avoiding a chromosomal Babel induced by multiple terminology.

Chromosomal abnormalities may be divided into two classes: those involving the sex chromosomes, and those involving the autosomal chromosomes. Classification may also depend on whether the abnormality is in chromosomal number or in chromosomal morphology.

Loss or gain of sex chromosomes appears to be one of the more common types of chromosomal abnormalities. Most cases of ovarian agenesis or Turner's syndrome have 45 chromosomes with an XO sex chromosome constitution resulting from the loss of one sex chromosome.[2]

In some cases partial deletion of one of the X chromosomes has been found. Most cases of Klinefelter's syndrome have been shown to have 47 chromosomes with an XXY sex chromosome constitution.[3] Since cases of Klinefelter's syndrome are phenotypically male, this indicates that the Y chromosome in man has a strong male determining effect. Females trisomic for the X chromosome have also been discovered. These individuals have 47 chromosomes with an XXX constitution.[4] They may be fertile but often suffer from menstrual abnormalities. Other abnormalities involving sex chromosomes such as XXXY and XXYY as well as various forms of mosaicism have been described. It should be noted that mental retardation sometimes accompanies sex chromosome abnormalities. It is apparent that explanations for many of the previously poorly understood sexual abnormalities have been developed from chromosomal studies.

Abnormalities in the autosomal chromosomes have also been described. The remarkable discovery of Lejeune et al.[5] that most cases of mongolism have 47 chromosomes is a landmark in understanding the pathogenesis of this common form of mental retardation. The child with mongolism is trisomic for chromosome 21. Edwards et al.[6] described a child with multiple anomalies trisomic for chromosome 17. Smith and Patau et al.[7,8] reported a child with 47 chromosomes with multiple anomalies who was trisomic for a chromosome of the group 13-15. Böök and Santesson[9] reported a remarkable patient with 69 chromosomes indicating that the child was trisomic for every chromosome. Several patients have been reported with both mongolism and Klinefelter's syndrome who have 48 chromosomes.[10] The failure to find examples of monosomy for any autosomal chromosome and the relative scarcity of trisomic autosomal syndromes indicates that, if anomalies of the autosomal chromosomes arise frequently in man, they seldom result in viable organisms.

Many of the chromosomal abnormalities appear to originate as a result of nondisjunction. During normal meiosis the two chromosomes of each pair separate so that each of the two daughter cells receives one of the pair. If both members of a pair of chromosomes are found in one daughter cell after meiosis, as a result of failure of normal pairing or separation, the phenomenon of nondisjunction has occurred. A study of sporadic mongolism indicates that nondisjunction, at least with regard to this disease, tends to increase in incidence with aging of the mother. A phenomenon quite similar to nondisjunction can occur in mitosis with the two daughter chromosomes derived from a single chromosome passing into one of the two daughter cells. This phenomenon apparently can occur during mitosis subsequent to fertilization and may result in mosaicism. In this remarkable state two or more stem lines of cells varying in chromosome number are present either intermixed in some of the same tissues or separate in different tissues of the same organism. Examples of mosaicism have been found in Turner's syndrome and more recently in rare instances of mongolism.

Translocation, the exchange of genetic material between two chromosomes of different pairs, also accounts for some of the chromosomal abnormalities of man. Partial deletion of chromosomes is also of importance.

The recent discovery by Nowell and Hungerford[11] of a specific chromosomal abnormality in most cases of chronic myeloid leukemia represents a milestone in the study of this disease. The anomaly involves one of the four smallest autosomal chromosomes. Approximately half of the substance of the chromosome is missing. Only the leukemic cells of the patient manifest the anomaly, which in all probability represents a somatic mutation. It should be recognized that while chromosomal abnormalities are found in some cases of acute leukemia, no specific chromosomal pattern has been found.

In a field as dynamic and active as that involving the chromosomal abnormalities of man it is difficult to project the course of future development. A firm foundation has been built by the pioneer investigators in the field. It is evident that the incidence of the chromosomal abnormalities already described will be determined. Examination of aborted fetuses will indubitably reveal the role of chromosomal abnormalities as a cause of abortion. It is likely that there will be more direct clinical application of the techniques already developed

for selected diagnostic problems. Even with further simplification of these techniques, however, it is extremely unlikely that chromosomal studies will ever become a routine diagnostic procedure. On the other hand, it is likely that during the next few years further remarkable discoveries in this field may be anticipated. Refinement in techniques may make possible the detection of more subtle chromosomal abnormalities. Aspects of the biochemical pathology associated with chromosomal abnormalities such as mongolism may be elucidated. The role of the abnormal chromosome in chronic myeloid leukemia may be determined. The significance of chromosomal abnormalities in other forms of neoplastic disease will be explored. It is in the additional clarification of fundamental problems in human biology and pathogenesis of disease in man that investigative work relating to human chromosomes has great promise.

IRA M. ROSENTHAL, M.D.

(References appear on page 42)

Mail Order Prescriptions

We received our first news release from a mail order prescription service. The appeal was aimed, as usual, at "the senior citizens, fighting the high cost of health" who, according to the release, "are turning to mail order prescriptions in great number. Getz Magady, president, Getz Prescription Company, expects his company's two year old mail order prescription service to double in sales volume in the next 12 months."

Mr. Magady claims many oldsters are paying over $50 a month for prescription drugs; he is able to offer savings as much as 40 per cent below conventional prices. This is possible because of high-volume sales on a national scale. Mr. Magady does it this way: He advertises in newspapers or national magazines listing prescription medications and vitamins by brand name and price. (Barbiturates and narcotics are not sold.) The customer fills in the ad coupon and sends along the original copy of his signed physician's prescription which must specify the number of authorized refills, if any. The prescription is filled and shipped out the same day.

According to Mr. Magady, most of the customers are the chronically ill. They obtain authorized refills simply by referring to the prescription number on the Getz label.

Prescriptions by mail are not new, and they are not limited to senior citizens. The current cry in Congress over the high cost of drugs and medical care has helped to keep the plan alive.

The American Pharmaceutical Association is Mr. Madagy's main opponent. It has been fighting mail order prescription schemes for years. The practice has been condemned as not in the best interest of the patient by the American Medical Association and state and local medical associations in all parts of the country. The dangers include delays encountered in obtaining the medication, the absence of the physician-patient-pharmacist relationship, the difficulties in checking the prescription files for strength and dosage, and the possibilities that prescriptions will be filled by nonprofessional personnel. All physicians should cooperate by keeping their patients informed relative to the dangers of these schemes.

Journal Changes

By now you are aware that your JOURNAL has undergone some marked changes with this issue. Actually there are several major changes that are not apparent but fit into the over-all plan to make this one of the finest state medical journals in the country.

One major change was to place the printing of the JOURNAL with Neely Printing Company here in Chicago. This was done after six months of careful investigation of the price, quality, and service of our former printer and of several others who bid on the job. We are confident that our choice was a wise one and are looking forward to a long and pleasant relationship with the Neely firm.

As a means of exerting better control over our advertising program, the Journal Committee recommended and the Council authorized me to place the advertising manager's position on a full-time basis. This will enable us to devote much more time to the business end of publishing your JOURNAL and should put it on a sounder financial basis.

With these steps taken, our full attention

was then given to a crew of artists, designers, and typographers to transform the magazine into a more readable, attractive, and modern publication. Robert D. Kral, a recognized expert in cover designing, came up with the new cover layout. Kral is art editor director for American Aviation Publications, Inc., largest aviation publishers of the world, and handles covers for five monthly magazines. His design was selected from a number of ideas, and we are proud to present it for your approval.

Another major change was in the type used. The type you are now reading was selected as the most readable, and, despite its apparently larger size, it gives us the same number of letters per line and the same number of lines per page as the old type. Title pages have a new look, too, to fit into the new design.

A good deal of time and effort have gone into redesigning your JOURNAL, but there is a limit to what we can do to make this the best state medical journal of all. We can apply our technical skills to the physical magazine, but we must rely on the physician members for other kinds of help to carry through our project. We need to know what you like . . . and don't like . . . about your JOURNAL. We'd like to know what features you read and which ones you consider dead items. Only you can tell us what is missing that you'd like to have included.

We have completed one important step in the renovation of the ILLINOIS MEDICAL JOURNAL, but we do not consider the job complete nor perfect. We are prepared to make further changes as we see the need for them. Please drop us a line and share your thinking with us.

AL BOECK
Director of Publications

Mr. Malley Leaves Journal After 20 Years

With the transfer of the printing of the JOURNAL to Neely Printing Company in Chicago, Mr. Edward Malley, an officer of Wayside Press, our former printers, leaves the JOURNAL as advertising manager.

Mr. Malley had been on the staff on a part-time basis since March, 1941. For many years he was responsible for the sale of ads, did mark-up of copy, and page make-up. He attended the annual meetings, where he learned to know many physicians, and took pictures for the JOURNAL.

Mr. Malley will remain as vice-president of Wayside Press, with which he has been connected for 30 years.

John Kinney Joins Headquarters Staff

John A. Kinney has been appointed to the staff of the Society as assistant director of publications and advertising and production manager of the JOURNAL. He began his duties August 28.



Mr. Kinney comes to us with a solid background in medical and pharmaceutical publishing. His experience the past 12 years includes publication management, editing, advertising sales and promotion on national publications.

Before joining our staff, he was assistant publisher of *Hospital Topics* and *Operating Room Nursing* magazines, published in Chicago by Gordon M. Marshall Company. He also served as assistant to the president in development and improvement of the publications and did national advertising sales for *Northwest Medicine, Southwestern Medicine, Western Journal of Surgery, Anesthesia and Analgesia, Abdominal Surgery, Physical Therapy,* and *Mental Hospitals.*

Prior to 1960 Mr. Kinney served for eight years as executive editor and sales promotion manager for the *Journal of the National Association of Retail Druggists,* Chicago. He joined the association staff in 1950 as managing editor. He also wrote and edited articles in pharmacy and business management for the journal.

Mr. Kinney is a graduate of Chicago Teachers College, holding an A.B. degree in education and has a graduate major in graphic arts.

Mr. Kinney continued his education in 1946-47 to teach printing and graphic arts in Chicago public high schools. He left teaching the following year to accept a position as advertising manager of a national publication in the music industry before joining the NARD.



at the EDITOR'S DESK

Flu Is Due

Dr. Luther L. Terry, Surgeon General of the Public Health Service, recommends immediate flu vaccination of the high risk group because of a possible epidemic this winter. This group consists of persons with heart or pulmonary disease; diabetes and other chronic illnesses; persons over 65; and pregnant women. His reasoning was based on the fact that Asian flu has been dormant here since March 1960, and it has been more than six years since we had much Type B flu in this country. Epidemics of Asian flu usually come in 2 to 3 year cycles and Type B every 4 to 6 years. Both types were prevalent in England last year, and we usually get it on the following year.

Pharmaceuticals

Thibenzole is Merck's new preventive and cure for trichinosis. The new drug was 100 per cent effective in protecting mice and swine when given at a level of 0.1 per cent in the diet. A single dose, if given promptly, completely cured mice of infections which were fatal for untreated mice. At larger doses in mice, Thibenzole destroyed the dormant trichinae larvae encysted in the muscle. Merck researchers do not know if the drug will have a similar action in swine and man, but they have their fingers crossed.

Merck also is sponsoring extensive clinical tests on alpha-methyl dopa, a decarboxylase inhibitor that shows promise of being an effective and safe antihypertensive drug. The product inhibits a decarboxylating enzyme whose action is essential to the production of the body of norepinephrine, serotonin, and other amines suspected of playing an important role in hypertension. However, the most recent findings indicate that alpha-methyl dopa lowers blood pressure not by inhibiting the decarboxylating enzyme but by lowering the levels of norepinephrine in the brain and peripheral nervous system. The drug is not available for general use by physicians.

Dr. Earl B. Herr, Jr., of Eli Lilly announced the discovery recently of a new antibiotic that kills streptomycin-resistant tubercle bacilli in mice. It is called capromycin and is just as potent as streptomycin or PAS in animals. The product has a limted range of activity. Its clinical evaluation is being planned.

Abbott Laboratories introduced a new oral antihypertensive combination of Enduron and Harmonyl, a diuretic and tranquilizer respectively. The Enduron component encourages sodium excretion, and the Harmonyl enhances the antihypertensive effect through its tranquilizing effect.

Parke-Davis recently completed research on a new antibiotic, Humatin, that effectively treats enteric infections. Their research clinician, Dr. Kenneth O. Courtney, was sent to check the various areas of the world where the drug was tried. He travelled over 200,000 miles to more than 35 countries to accumulate adequate evaluation of its safety, efficacy, and optimum dosage.

P-D is sponsoring clinical investigations of tropical diseases in many countries, hopeful that new drugs will be developed for present diseases. Their research must be promising because they expect to expand the program.

Report on M.D. Physicals

Results of the physical examinations given 1,900 physicians during the annual meeting of the American Medical Association in New York City last month have been announced.

Electrocardiograms revealed heart abnormalities in 17.7 per cent of 1,945 physicians, according to Dr. Charles E. McArthur, Olympia, Wash., chairman of the AMA Committee on Annual Physical Examinations for Physicians.

Dr. McArthur said he was impressed with the consistency of the data during the seven years the M.D. physicals have been given at AMA annual meetings. Despite the fact that each year there is a different group of examinees and different consultants, the normal electrocardiograms have been close to 80 per cent each year, he said.

Chest x-rays of 1,900 physicians showed:
Suspected tuberculosis in 5.3 per cent.
Other lung abnormalities in 6.1 per cent.
Cardiovascular abnormalities in 6.7 per cent.
Other conditions in 6.7 per cent.

Blood Bank Controversy

A bloody but friendly battle is being waged in Chicago over the world's first blood band. Credit for this honor was recently given to the Cook County Hospital by the American and Illinois associations of blood banks. They presented a plaque honoring the hospital and the late Dr. Bernard Fantus, founder of the blood bank in 1937 (See News).

But Dr. John Lundy, retired Mayo Clinic anesthesiologist, claims that he started the first bank in 1935 and has a published article to prove it. The controversy centers about definition and how many pints of blood must be stored in an ice box before it becomes a bank. In 1935 banks were not too popular, and perhaps Dr. Lundy was afraid to give the blood room a proper title. We must also admit that it didn't take much (of anything) to make a bank in those days, and storing four pints was enough to warrant the title "bank." At any rate, Dr. Lundy came originally from Chicago and is now working in Chicago and intends to remain in Chicago. So far as we are concerned it's all in the family, and the world's first blood bank is a Chicago affair.

Taxes, Taxes, Taxes

Claims for social security benefits received in the Nation's 600 social security district offices have hit an all-time high as a result of the amendments signed by President Kennedy on June 30, Victor Christgau, director of the Bureau of Old-Age and Survivors Insurance, announced recently.

Under the 1961 amendments to the old-age, survivors, and disability insurance program:

1. Retired men now have the option to collect reduced social security as early as age 62.
2. Aged widows' benefits increased in September by about 10 per cent.
3. People getting lowest-rate benefits also received increased payments in September.
4. The amount of work needed to qualify for benefits is reduced.
5. Beneficiaries who work have less money withheld from their benefits—they can now get more in combined earnings and benefits than they would have had under the old law.
6. Social security taxes will be increased by one eight of one per cent each for employees and employers beginning Jan. 1, 1962; by .2 of one per cent for the self-employed.
7. The deadline for disabled workers with long-standing disabilities to apply for disability benefits is extended one year.

Antitrust Suit re Antibiotics

The antitrust suit recently filed against Pfizer, two other drug firms, and the board chairman or president of each firm charges that the defendants conspired to restrain trade, monopolize antibiotic production and sale, and fix prices. Pfizer had the following to say regarding these charges:

(1) This antitrust suit is completely different from recent highly publicized cases in another industry, where competitors specifically agreed on prices at meetings, and it was reported that persons involved admitted their guilt.

(2) In this antibiotic suit no such meetings are charged. The suit is based chiefly upon inferences and suspicion—a suspicion that since published prices of certain antibiotics in some markets tended to find a common level, collusion must have been involved. Such a collu-

sion is not justified in fact or in law. In fact, vigorous competition existed.

(3) Actually, the antibiotics suit can be compared to the Salk polio vaccine antitrust case, which relied heavily upon inference and suspicion. That case was dismissed by the court for lack of adequate evidence.

(4) This suit involves nothing new. All of the alleged grounds upon which it is based have been thoroughly sifted and re-sifted by various Federal agencies over years of investigations and many months of hearings.

(5) Pfizer, its president, and all other members of its management have joined in a strong denial of the charges in the suit. This suit will be vigorously contested.

(6) We hope that American fair play will prevail in this situation, and that any judgment of the defendants by the public will await the final decision of the court. We are confident of the outcome.

To What Purpose?

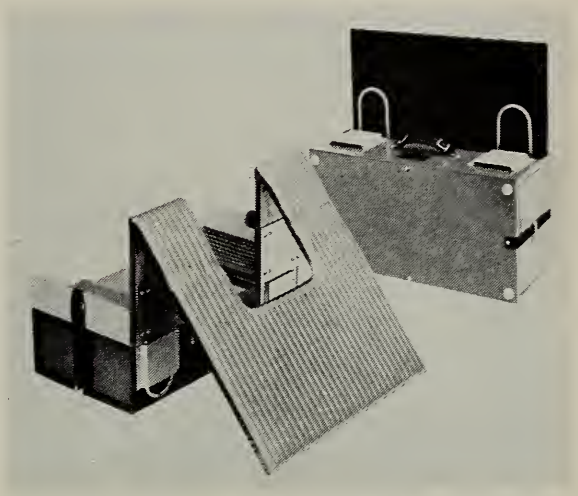
Secretary Abraham Ribicoff of HEW has been busy sending reports on the radioactive fallouts from the Russian resumption of testing nuclear weapons. The newspapers have carried most of these releases, and Americans are keeping tab on the level as they do long holiday weekend deaths, pollen counts, and baseball statistics. We are not trying to underestimate the magnitude of the action taken by the Soviet government, but we wonder what purpose these reports serve. Perhaps the people of our country and those of the world should realize the threat of contamination of food, water, and air. But we hope it is not being done to prime or soften our citizens for war.

It is difficult to think clearly during these psychologic skirmishes: and nations, like people, often crack under the strain.

What's New?

Remington Rand has designed a new line of chairs to fit people. The chairs range in color and luxuriousness from the "800" Executive Posture Chair through a variety of secretarial and clerical chairs. The posture chairs have five adjustments: seat height, tilting tension, backrest height, backrest depth, and backrest tension. They also announced a radical new secretarial chair called the "Adjust-A-Matic," which has a divided seat designed to the movements of the body. This I must see to believe.

Bet on a proctologist the next time you see a gentle looking man enter a home with a physician's bag in one hand and a large, compact case in the other. He is making a house call and carrying a new Sierra-Spinger portable protologic rest. His patient may or may not realize that he is about to get the full treatment.



Sierra-Springer protologic rest

The unit is adjusted to accommodate patients for rectal examinations—in comfort. "Knee rests and leaning plate are fully padded. The opening in the leaning plate . . . permits placing of abdomen in open area to leave the patient completely relaxed and comfortable with thighs and abdominal muscles tended forward and downward, allowing the physician a greater exploratory field without obstruction."

It might sound more inviting if it included a velvet-covered proctoscope.

Deet It Do

A new insect repellent is being issued to Army personnel. It is called "deet" after the active ingredient, the meta isomer of diethyltoluamide. It is greaseless and repells most insects, including mosquitoes, fleas, chiggers, ticks, deer flies, and biting gnats. It is effective under conditions of heavy rainfall and extreme heat. Deet was developed several years ago by the U.S. Department of Agriculture with Army medical research funds.

Official Business

Committee on Aging Develops Care of Stroke Patient Program

Judging from audience response, the new demonstration programs on Care of the Stroke Patient have a great future. They were presented in East St. Louis and in Belleville last month.



Dr. Edward Gordon, Chicago, conducting demonstration in the Care of the Stroke Patient program.

The ISMS Committee on Aging has developed the programs, which were presented with the cooperation of the Illinois Heart Association, the State Department of Public Health, and the Division on Aging of the Illinois Public Aid Commission. The St. Clair County Medical Society's Committee on Aging joined with the Society as sponsor.

These are pilot projects—one for a metropolitan area and the other for a rural area—designed to find out how to approach physicians, nurses, nursing homes, and possibly families to explain how to improve the care of the stroke patient. Three points are stressed: proper positioning, early ambulation, and self help.

Ninety physicians attended the evening meeting of the county society, which later appointed a subcommittee to implement the recommendations made.

Over 150 registered nurses, licensed practical nurses, hospital, and nursing home personnel attended each of the demonstrations at St. Mary's Hospital in East St. Louis and St. Elizabeth's Hospital in Belleville. A permanent committee of directors of nurses of the five hospitals in the area will work with the county society committee.

The program, which created a great deal of enthusiasm, was directed by Dr. Edward Gordon, director of the department of physical medicine, Michael Reese Hospital, Chicago, with Dr. Louis D. Boshes of Michael Reese, and Dr. Oscar Sugar, department of neurosurgery, University of Illinois.

ISMS Warns of Perils To Children's Eyes

With the reopening of schools, the Public Safety Committee of the Illinois State Medical Society emphasized the need for protecting the eyes of children in school and at play. The committee recommended that children who wear glasses should have lenses made of shatter-proof material, which look no different from those made of ordinary optical glass but provide greater protection against injuries to the eye.

Noting the increasing emphasis on science studies in grammar and high schools, the com-

mittee urged that safety spectacles be provided not only in school shops but in all laboratories where there is danger, however remote, of mechanical parts breaking or of chemical explosions. Safety glasses also were recommended for those with poor vision in one eye irrespective of the need for lenses to correct the vision of the better eye.

The committee warned against the wearing of contact lenses in chemical laboratories where irritating chemicals could be captured behind the lens and not be rapidly washed out of the eyes by tears. They warned also of the danger of infection arising when contact lenses were worn after the eye became irritated or the vision cloudy.

The state law insists on a physical examination every four years for children in primary and secondary schools. The eye portion of these examinations is incomplete since it is designed principally to find children with defective vision. The committee emphasized the value of a complete eye examination to rule out organic disease even though vision is normal.

Report on Relative Value Study

Tabulation of the Relative Value Survey is in progress. On September 1 questionnaires were mailed to each physician in Illinois requesting him to report his usual fees for the medical procedures he actually performs. Completed questionnaires started to pour into the state office shortly after Labor Day, and editing began. The study was authorized by the 1961 House of Delegates to obtain data for the purpose of developing a *preliminary* Relative Value Index.

The deadline for completed questionnaires was set for September 11. However, due to delay in 3rd class mail delivery, some physicians had not received their questionnaires by that date. Therefore, on September 15 letters went out to all physicians asking them to disregard the September 11 deadline and to return completed forms as soon as possible. The response was immediate and was appreciated by the Relative Value Committee. It was necessary to mail follow-up letters to all physicians since the questionnaire was anonymous, and it was impossible to contact those physicians who had not completed the forms by the deadline.

The dollar amounts reported in the questionnaires will *not* be shown in the final report. They are being converted into *unit values* and will be expressed in numerical relationship to other procedures and services to form a Relative Value Index.

The statistical analysis is being made by two professional statisticians appointed by the Relative Value Committee. They are Frederick Ekeblad, Ph.D., and Boris Parl, Ph.D., both of whom are on the faculty of the Graduate School of Business Administration, Northwestern University; Dr. Ekeblad is also the chairman of the department of business statistics.

As soon as the tabulations are completed and the Relative Value Index is formulated, it will be mailed to members of the House of Delegates for their consideration several months prior to the 1962 annual meeting in May. The Index will not be released for general use until acted upon by the House.

The Relative Value Index can be used scientifically to establish fee schedules as a substitute for existing fee schedules which came into being, for the post part, without a realistic relationship to the actual fees for professional services and which have little or no statistical validity. The Relative Value Index provides a useful guide which physicians, as a group, may use in dealing with governmental and other third-party programs. It may also be used as a guide to individual physicians for pricing their services.

The committee, headed by C. Elliott Bell, M.D., Decatur, appreciates the cooperation of the physicians on this survey.

Pilot Membership Drive Proposed

The American Medical Association has requested permission of the ISMS to use Illinois as a testing ground for a pilot membership project to enlist eligible physicians. The object of the joint program of the AMA and ISMS is to assist the respective county societies to obtain new members.

The proposal was made at the Committee Workshops meeting September 17 by Mr. Robert A. Enlow of the AMA, emplementing

(continued on page 260)

Official Business *(continued from page 259)*
the action of its 1960 House of Delegates to encourage state medical societies to extend full membership to all eligible and qualified physicians.

The Society, through its newly appointed Membership Committee, amended its constitution in the House of Delegates last May (See Article X—Dues and Expenses).

The AMA proposes to prepare a listing of all eligible Illinois physicians not now members of the AMA, arranged by county and city, indicating also professional interest and licensure in Illinois. Lists will be made available to county societies.

According to Mr. Enlow, there are approximately 3,000 physicians in Illinois who, though eligible under our present Constitution and Bylaws, are not members of the county and state societies.

The AMA hopes to work with the county societies through their respective state societies. In Illinois the proposal would be implemented through the Society's Membership Committee, which is made up of Dr. H. Close Hesseltine, chairman, the deans of the five medical schools, and Drs. Fred C. Endres with Walter C. Bornemeier—ex-officio.

Benevolence Committee Meets

The Benevolence Committee held its organization meeting in the Chicago offices of the Society September 5. Dr. Keith H. Frankhauser of Avon will serve as chairman. Drs. Irving H. Neece, Decatur, and F. M. Nicholson, Chicago, are other members of the committee.

Items considered in determining committee policies were as follows:

1. Need for additional funds to meet present payments to beneficiaries
2. Plans whereby the fund may become self-sustaining
3. Information that must be on file at headquarters on all cases. It was decided that each case will be reviewed annually to keep payments within the financial structure of the fund.

Special Meeting
ISMS House of Delegates

Subject: Proposed Administration of the Kerr-Mills Law in Illinois by the IPAC

Business and resolutions regarding the subject of the special call may be introduced by county medical societies. Any member of ISMS may appear before the Reference Committee to present his views on the subject.

First meeting: Saturday, Oct. 28, 1961, 7 p.m.
Second meeting: Sunday, Oct. 29, 1961, 11 a.m.
Sheraton-Chicago Hotel—Tallyho Room

NEW...made from 100% corn oil UNSALTED MARGARINE FOR HYPERTENSIVE PATIENTS

* contains only 10 mgs. of sodium per 100 grams
* contains 50% liquid corn oil and 50% partially hydrogenated corn oil
* has 30% linoleic acid—10 times that of butter

Because of the relationship of high-sodium intake to elevated blood pressure, new Fleischmann's Unsalted Corn Oil Margarine will prove to be a valuable addition to the dietary regimen of your hypertensive patients. It contains only 10 mgs. of sodium per 100 grams.

Fleischmann's Unsalted Margarine is made from 100% corn oil and contains both liquid corn oil and partially hydrogenated corn oil. Its linoleic acid content of 30% is three times higher than the 10% of regular margarines and ten times higher than the 3% of butter. This is the *only* unsalted margarine made from 100% corn oil.

The substitution of Fleischmann's Unsalted Corn Oil Margarine for butter or ordinary margarines in your hypertensive patients' dietary regimen has the added advantage of increasing their intake of high polyunsaturates . . . important because of their association with hypertension and atherosclerosis.

If your hypertensive patient needs sodium restriction, recommend Fleischmann's Unsalted. It has a light, delicate taste that he'll like. Tell him that it is available in his grocer's frozen food case.

Write now for physician booklet of 5 coupons—each coupon redeemable by your patient for 1 lb. of Fleischmann's Unsalted Margarine. Address Fleischmann's Unsalted Margarine, 625 Madison Avenue, N. Y. 22, N. Y. *Distribution presently limited in some areas.*

In line with the suggestion of the American Heart Association to manufacturers, we are listing the fatty acid composition of Fleischmann's Unsalted (Sweet) Margarine:

Unsaturated Fatty Acids:	
Polyunsaturates	30%
Monounsaturates	50%
Saturated Fatty Acids	20%
	100%

AVERAGE DAILY INTAKE
Two Ounces or Eight Pats of Fleischmann's Corn Oil Margarine Will Supply

Corn Oil—Liquid	22.7 Gm.
Corn Oil—Partially Hydrogenated	22.7 Gm.
Iodine Value	90-95
Sodium (dietetically sodium-free)	6 Mgs.
Linoleic Acid	13.6 Gm.
Vitamin A (Adult's Need)	47%
Vitamin A (Child's Need)	62%
Vitamin D (Adult's and Child's Need)	62%



Fleischmann's
Fresh-Frozen in the green foil package
in your grocer's frozen food case

ONLY UNSALTED MARGARINE MADE FROM 100% CORN OIL

NEWS of the STATE

Dr. Foley Appointed Dean

Dr. Edmund J. Foley, chairman of the department of medicine and chief of staff, Cook County Hospital, assumed the deanship of the Cook County Graduate School of Medicine September 1. He will continue to serve as the institution's chief of staff.



Dr. Edmund J. Foley

He is attending physician at University of Illinois, Garfield Park, and Columbus hospitals and has been associated with County Hospital since 1921, serving for many years on its board of trustees.

New Illinois Eye Bank Consultant Named

The Illinois Society for the Prevention of Blindness appointed Charles W. Daugherty, R.N., consultant to the Illinois Eye Bank. He succeeds Miss Stella L. Brueggen, R.N., who resigned in July (see August JOURNAL).

Mr. Daugherty had previously been director of nurses and assistant administrator, Hazel Crest General Hospital. He is a graduate of the School of Nursing, St. John's Hospital, Pittsburgh, Pa., and did postgraduate work at Cook County Hospital and the School of Anesthesia, Jewish Hospital, Philadelphia.

Commemorate First Blood Bank Founding

The establishment of the world's first blood bank at Cook County Hospital was commemorated at a luncheon in Chicago September 7. The hospital and the late Dr. Bernard Fantus, founder of the blood bank in 1937, were honored by a plaque presented by the American and the Illinois associations of blood banks. Dr. John R. Shenken, president of the American Association of Blood Banks, was the main speaker.

The luncheon launched "Know Your Blood Bank Week," a project to inform the Chicago public on the vital services performed and the facilities available to them through the 55 Chicago community blood bank programs.

Last year blood banks in Cook and DuPage counties collected 181,000 pints of blood from donors. Approximately 161,000 units were used for transfusion and the remaining ones converted to plasma or derivatives.

There are two major sources of blood in Chicago's community blood banking program: (1) the community blood bank that draws blood from donors and makes it available to hospitals; and (2) the hospital blood bank that draws from donors to meet its specific needs.

Blood, including rare types, is always available in Chicago, and the blood bank facilities are spread out to assure blood in any emergency. A recent survey showed that 40 per cent of the community blood banking facilities here could supply approximately 1,200 pints of blood already processed and ready for transfusion on immediate call. An additional 1,200 pints could be delivered within four hours; during the next four hours another 1,200 pints could be ready.

Grants for Research

Presbyterian-St. Luke's Hospital has received a $107,000 research grant for the development of a live-type mumps virus vaccine. The research is sponsored by the National Institutes of Health and will be conducted over a three-year period.

Dr. Friedrich Deinhardt, chairman of the department of microbiology, has been named principal investigator, and Dr. Richard B. Capps of the attending staff will be his clinical consultant.

Mumps viruses from human cases will be propagated in successive passages in chick embryos.

Dr. Deinhardt helped to develop the present killed-type mumps vaccine while at the University of Pennsylvania and the Children's Hospital in Philadelphia.

• A 372,360 three-year grant to the department of surgery, University of Chicago, from the John A. Hartford Foundation, Inc., will enable it to intensify studies on pulmonary hypertension.

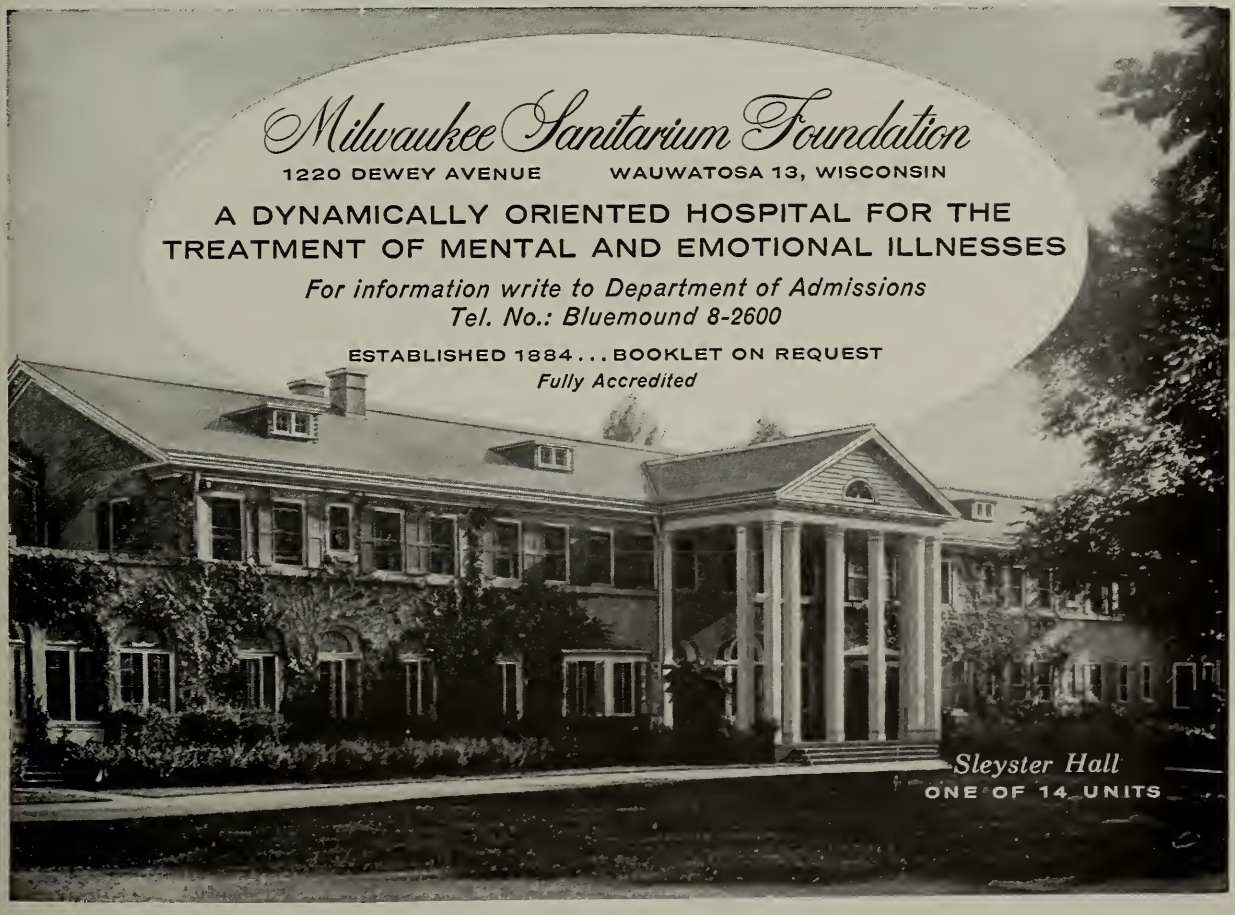
A nine-man research team will be headed by Dr. William E. Adams, Raymond Professor of Surgery and chairman of the department; Dr. Peter V. Moulder and Dr. Robert W. Harrison, associate and assistant professors respectively in surgery; and Dr. Donald E. Cassels, professor of pediatrics.

Appointments

Dr. George L. Snider, consultant physician and director of the Pulmonary Function Laboratory, Municipal Tuberculosis Sanitarium of Chicago, has become chief of the Division of Thoracic Medicine at Mount Sinai Hospital. He is also an attending physician at Mount Sinai Hospital and at Winfield Hospital in Winfield. Previously he was assistant director of the chest department of Michael Reese Hospital.

He is president of the Illinois chapter and a fellow of the American College of Chest Physicians and is a fellow of the American College

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for potential ulcer...
to relieve tensions and to inhibit
hypermotility and hypersecretion

PATHIBAMATE®

PATHILON® tridihexethyl chloride Lederle with meprobamate

highly effective with minimal side effects for therapeutic/prophylactic treatment of duodenal ulcer, gastric ulcer, intestinal colic, spastic and irritable colon, ileitis, esophageal spasm, anxiety neurosis with gastrointestinal symptoms, gastric hypermotility. CONTRAINDICATIONS: glaucoma; pyloric obstruction; obstruction of the urinary bladder neck. Request complete information on indications, dosage, precautions and contraindications from your Lederle representative or write to Medical Advisory Department.



for patent ulcer...
to relieve tensions and to inhibit
hypermotility and hypersecretion

PATHIBAMATE

PATHIBAMATE-400 (full meprobamate effect)—1 tablet t.i.d. at mealtime, and 2 tablets at bedtime · PATHIBAMATE-200 (limited meprobamate effect)—1 or 2 tablets t.i.d. at mealtime, and 2 tablets at bedtime · Adjust to patient response. Each Pathibamate-200 tablet contains: PATHILON, 25 mg.; meprobamate, 200 mg. Pathibamate-400 tablets contain 400 mg. meprobamate.

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

State News *(continued from page 265)*

of Physicians and a member of the Illinois Society of Medical Research and the American Thoracic Society.

The department of psychiatry at Presbyterian-St. Luke's Hospital has a new chairman —Dr. Paul E. Nielson, who took over in that capacity on September 1. His other posts include attending psychiatrist at Cook County Hospital, the West Side Veteran's Administration Hospital, and Presbyterian-St. Luke's; in April he was appointed a member of the Psychiatric Training and Research Authority in the Illinois Department of Public Welfare.

In addition, he is an associate professor of psychiatry at the University of Illinois College of Medicine, where he has taught since 1948. He has a membership in the American Psychiatric Association and is a diplomate of the American Board of Psychiatry and Neurology.

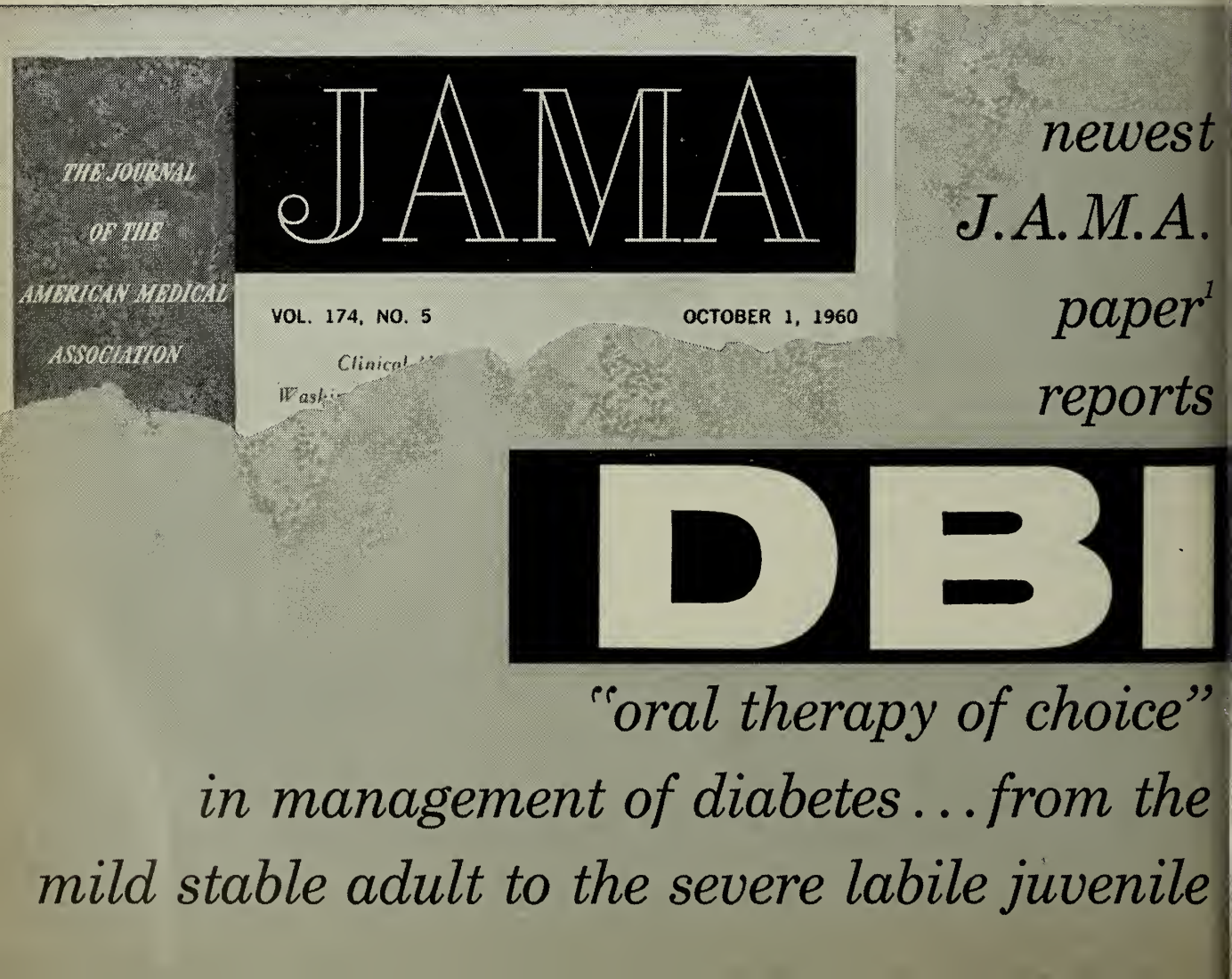
Dr. George E. Maha and Dr. Howard R. Miller were named staff physicians at the University of Illinois, effective September 1.

Dr. Maha, who has been appointed associate professor of hygiene, is a native of Elgin and had been a physician with Lilly Research Laboratories, Indianapolis.

Dr. Miller, who has been engaged in private practice in Peoria since 1939, will hold the rank of assistant professor of hygiene.

The appointment of John T. Wilson, Washington, D. C., a senior officer of the National Science Foundation and psychologist, as special assistant to chancellor George Wells Beadle of the University of Chicago became effective October 1. Mr. Wilson also will be a professor in psychology and do research. For at least a while he will work closely with R. Wendell Harrison, vice president and dean of the faculties, and vice president Lowell T. Coggeshall.

In 1952 Mr. Wilson joined the NSF to direct its program in experimental psychology, and for the past six years he was assistant director for biologic and medical sciences.



Elections

The Chicago Society of Allergy choose the following officers at a recent meeting: Dr. Charles M. Jenkins, president; Dr. Abe Matheson, president elect, and Dr. Ethel M. Davis, secretary-treasurer.

Dr. Heinz Kohut, Chicago, was elected secretary of the American Psychoanalytic Association at its annual meeting in May.

At the last Congress of the International Psycho-Analytic Association in Edinburgh, Scotland, in July Dr. Maxwell Gitelson of Chicago was elected president.

Dr. Gitelson is the eighth analyst to hold this office in the past 50 years and is successor to such eminent men at Ernest Jones, Jung, and Abraham. He is the second American-trained analyst to be elected to this office.

At the present time he has taken temporary leave from his practice to accept the visiting Sloan Professorship at the Menninger Clinic.

Deaths

Edmund M. Arnold*, Chicago, a graduate of the University of Illinois College of Medicine in 1908, died July 4, aged 85. He was a member of the 50-Year Club and an emeritus member of the Illinois State Medical Society.

Victoria M. Barnes, retired, Chicago, a graduate of the Bennett Medical College in 1908, died September 2, aged 77. She had practiced in Chicago and Gary over 50 years.

George F. Barry*, Evanston, a graduate of the Hahnemann Medical College, Philadelphia, in 1902, died August 27, aged 86. He had practiced in the Chicago area for 59 years and in his early years was on the staff of Evanston Hospital at one time teaching pharmacology to student nurses there. In 1953 he received an award from the Evanston Chamber of Commerce for contributions to the community. He was a member of the 50-Year Club of the Illinois State Medical Society and the senate

(continued on page 36)

results of 104 "problem" diabetics treated with...

fair to excellent control in 91 of 104 diabetics (88%)
... achieved with DBI use alone or combined with exogenous insulin.

"more useful and certainly more serene lives"...
In many diabetics "phenformin (DBI) has been responsible for adjusting life situations so that patients whose livelihood was threatened, whose peace of mind was disturbed because of lability of their diseases, have been restored to more useful and certainly more serene lives."

"no evidence of toxicity" due to DBI...
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Deaths *(continued from page 35)*

of seniors of the American Institute of Homeopathy.

ALEXANDER O. BIRGERSON*, Granville, a graduate of the University of Illinois College of Medicine in 1934, died July 13, aged 54. He was past president of the Bureau County Medical Society and president of the Putnam County Tuberculosis Sanatorium board. During World War II he was medical examiner for the Selective Service and in 1950 became medical adviser to the Putnam County Selective Service Board. He was on the staff of St. Margaret's Hospital, Spring Valley, and a former coroner of Putnam County.

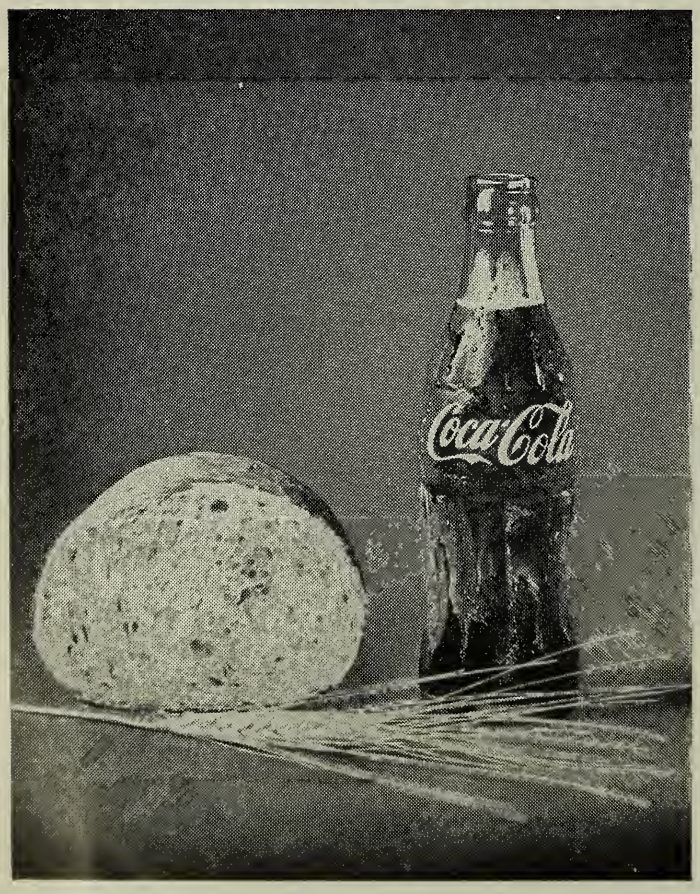
HARRY L. COLLINS, Ottawa, a graduate of Loyola University School of Medicine in 1918, died August 12, aged 69. He was chief surgeon of Chicago Osteopathic Hospital from 1918 to 1952 and was past president of the American College of Osteopathic Surgeons and of the Chicago College of Osteopathy, of which he was a graduate.

JOHN F. DEAL*, Springfield, a graduate of the Northwestern University Medical School in 1911, died August 13, aged 76. He did a year's postgraduate work in Vienna and had been an attending physician on the staff of the Palmer Sanatorium and Springfield Hospital. He was certified in otolaryngology in 1927 and was a member of the Board of Otolaryngology and Ophthalmology, the Phi Rho Sigma fraternity, and a charter member of the Springfield Rotary Club.

JOHN F. DYBALSKI, Chicago, a graduate of Loyola University School of Medicine in 1921, died February 14, aged 64.

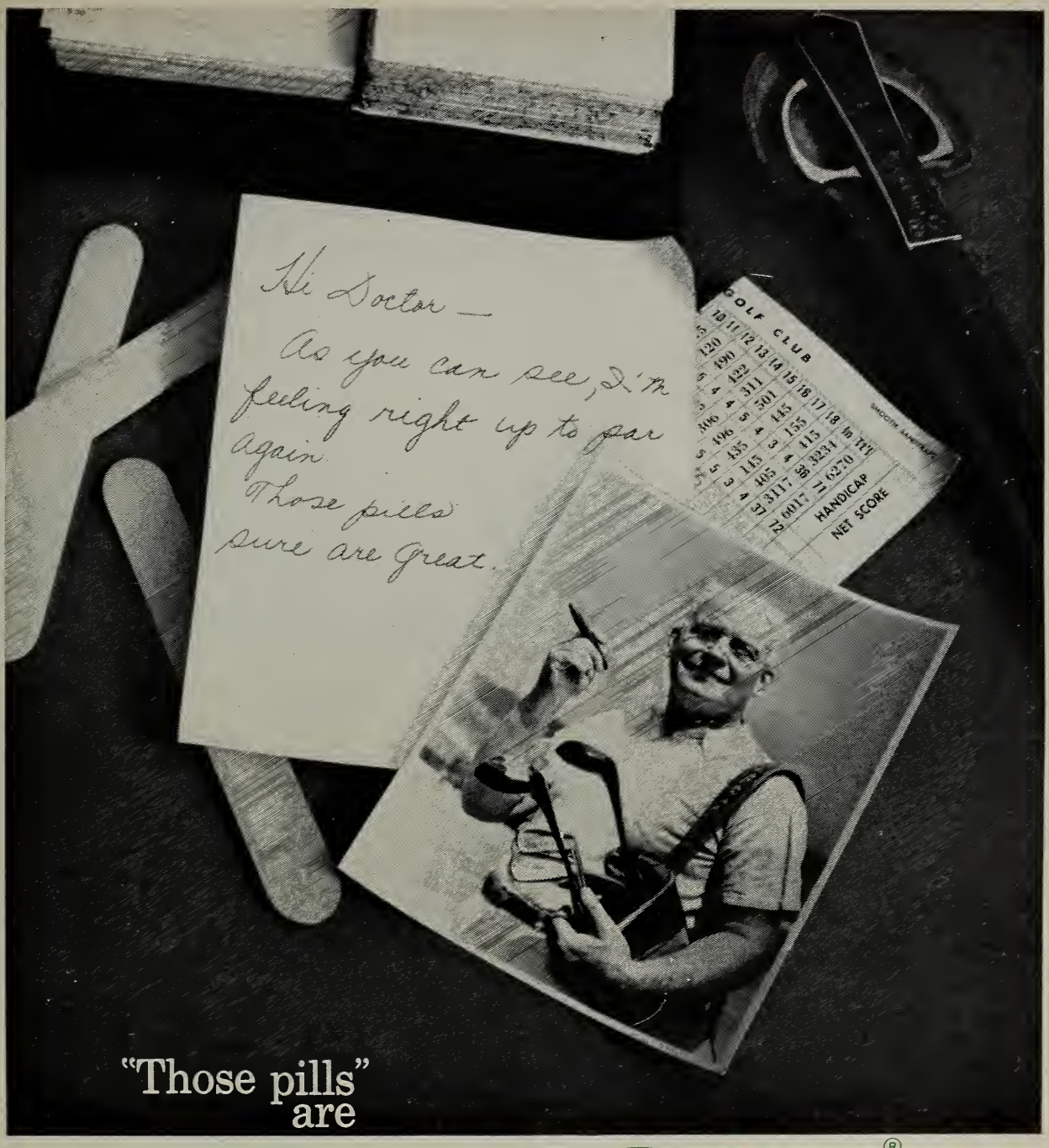
WALTER R. FALLON*, Chicago, a graduate of the University of Illinois College of Medicine in 1929, died July 31, aged 65. He was an attending physician at St. Joseph and Cook County hospitals for decades, and was a fellow of the American College of Surgeons and a founding fellow of the American Association of Obstetrics and Gynecology. He was certified

(continued on page 40)



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Deaths *(continued from page 36)*

in obstetrics and gynecology in 1951 and had been a clinical instructor in obstetrics at Stritch School of Medicine of Loyola University since 1944.

James T. Groot, Chicago, a graduate of the University of Illinois College of Medicine in 1924, died August 6, aged 75. He had been a Chicago physician for 37 years and was on the staff of Belmont Hospital.

J. Carl Hall*, Centralia, a graduate of the Northwestern University Medical School in 1910, died August 13, aged 75. Dr. Hall, who was a nephew of Dr. Andy Hall of Mt. Vernon, had practiced in Centralia since 1911. He was a member of the 50-Year Club of the Illinois State Medical Society. In World War I he received the Silver Star and achieved the rank of major, serving as chief surgeon of an American Red Cross Hospital in Russia. In World War II he was a medical examiner for the Selective Service.

Dr. Hall had been a staff member of St. Mary's Hospital since 1913, was chief surgeon of the Veterans Bureau in Southern Illinois in 1920-21, and was local surgeon for the Missouri Pacific and Southern railroads.

Dr. Hall was a trustee of the Centralia Foundation and donated and maintained J. Carl Hall Park, a 39-acre section of the Foundation park system. Active in community affairs for more than 50 years, he was a charter member of the Rotary Club, a member of the Masonic Lodge and local, state, and federal Chambers of Commerce, and was president and owner of the Central City Lumber Company.

Henry H. Hurd*, retired, East St. Louis, a graduate of the St. Louis University School of Medicine in 1927, died June 21, aged 62.

Wayne P. Kisthard*, Camp Point, a graduate of the University of Colorado School of Medicine in 1958, died August 5. He was 36 years of age.

(continued on page 42)

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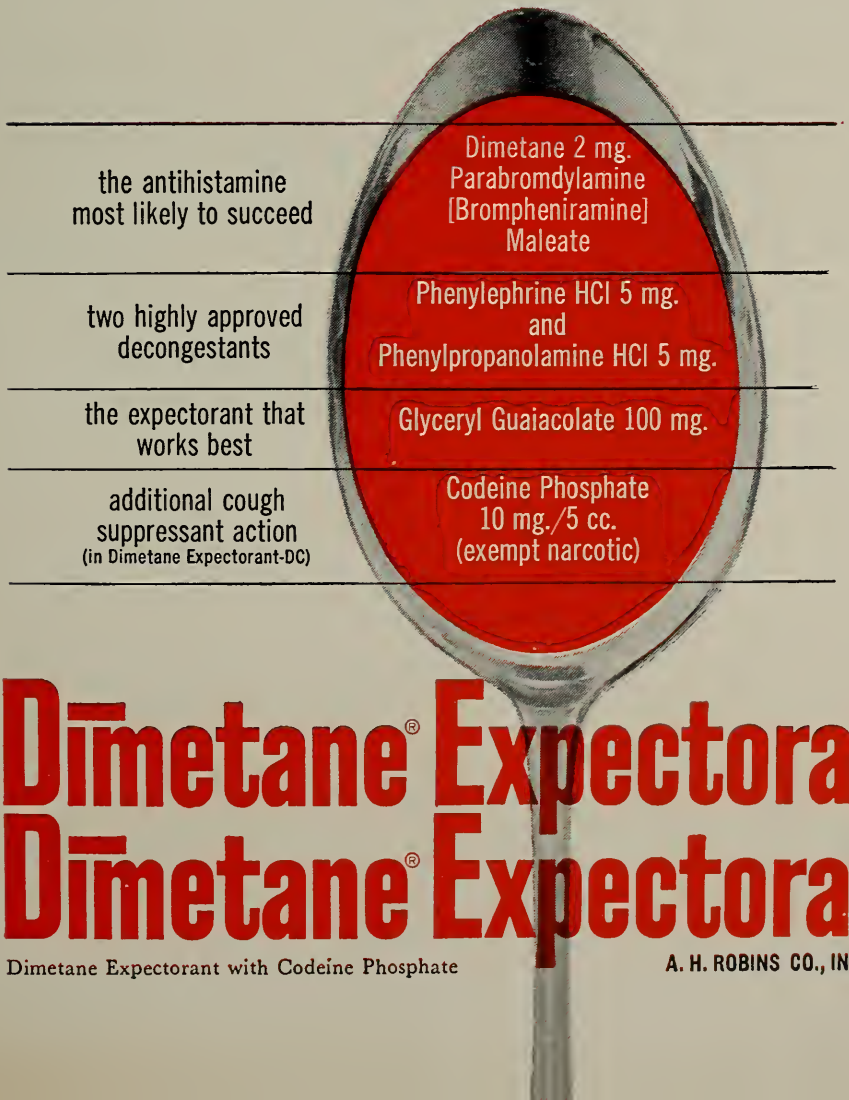
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Deaths *(continued from page 40)*

Robert W. Patchell, Chicago, a graduate of the Chicago Medical School in 1933, died August 1, aged 54.

Marcus A. Quinones*, Lewistown, a graduate of the State University of Iowa College of Medicine in 1925, died August 13, aged 65. He had practiced in Lewistown since 1926 and was on the staff of Graham Hospital. He was in military service during World War I.

William A. Ribbeck*, Eustis, Fla., a graduate of the Northwestern University Medical School in 1907, died February 24, aged 80. He was an emeritus member of the Illinois State Medical Society and 50-Year Club member.

Ralph R. Ritzman*, Aurora, a graduate of the University of Pennsylvania School of Medicine in 1918, died August 14, aged 69. He had been on the staffs of St. Joseph Mercy and St. Charles hospitals in Aurora and did a year's postgraduate work at the University of Wisconsin Medical School.

**Indicates member of Illinois State Medical Society.*

*Addenda to "Chromosomal Abnormalities in Man". Concluded from page 253.

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Published monthly by the Illinois State Medical Society, 360 N. Michigan Avenue, Chicago 1, Ill. Subscription $5.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, and Mexico. $7.00 per year for all foreign countries included in the postal union. Canada, $5.50. Single current copies 75 cents.

Second class postage paid at Chicago, Illinois. POSTMASTER: Send notices on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago 1, Ill.

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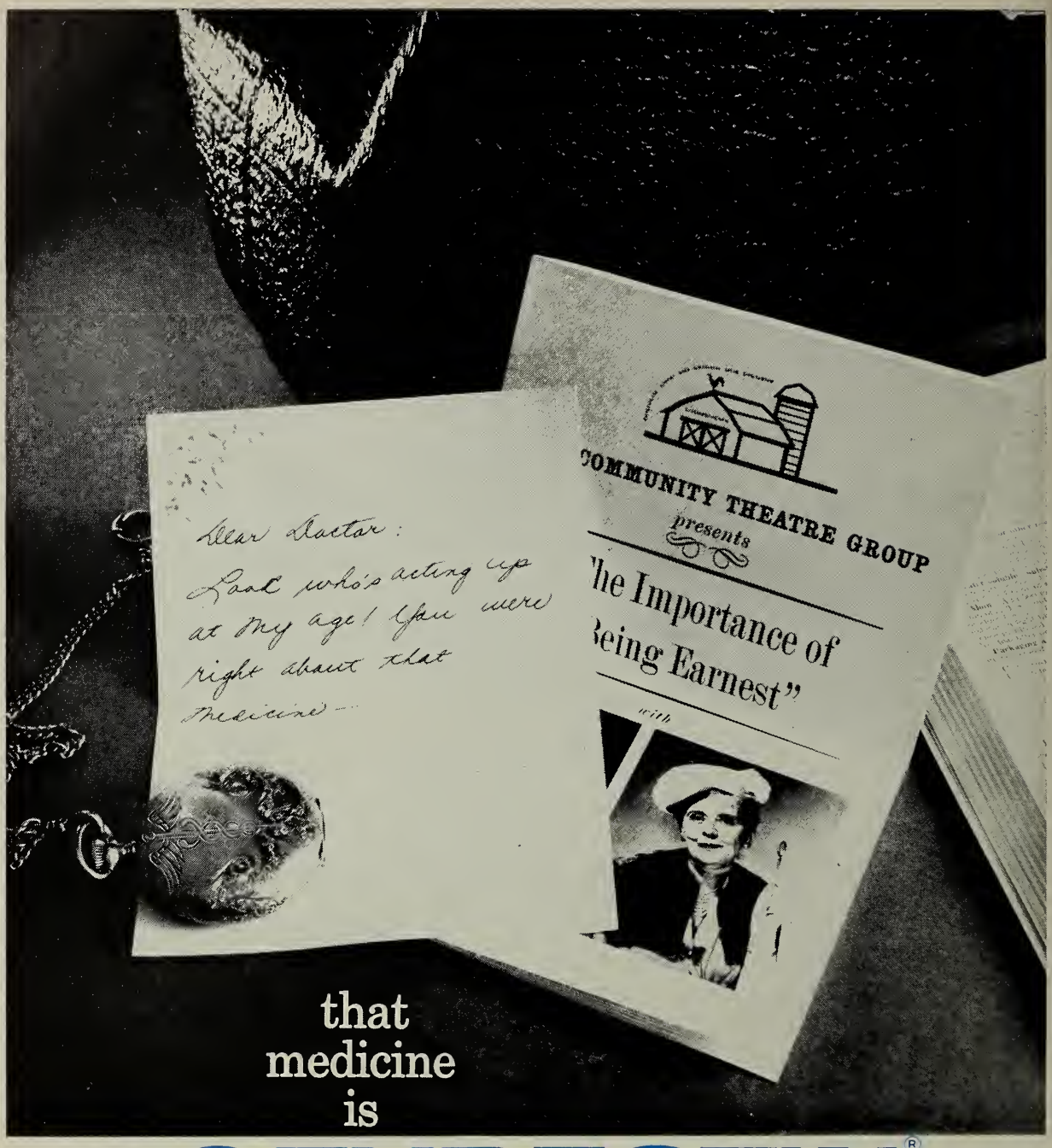
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Abstract of House of Delegates Action

Special Meeting, October 28-29, 1961

The House of Delegates of ISMS met in special session on October 28 and 29 to consider a report by an Ad Hoc Committee which has been conferring with IPAC on the implementation of the (Kerr-Mills) Aid to the Medically Indigent Aged program in Illinois.

The following amended Reference Committee Report was unanimously adopted by the House of Delegates.

Report of Reference Committee #1

Mr. Chairman and members of the House of Delegates:

The committee received the report of the Ad Hoc Committee on the Kerr-Mills program, and all resolutions pertaining to the implementation of the Kerr-Mills Law in Illinois. In the open discussion, which lasted more than two hours, more than 50 opinions were received and evaluated.

We wish to thank all the members of the Ad Hoc Committee and of the society who participated in the hearing for their orderly, informative discussion and cooperation during the session.

We believe the Ad Hoc Committee deserves commendation for the comprehensive evaluation of the problem. We concur in principle with the recommendations embodied in the last paragraph of the Ad Hoc Committee report.

The recommendations of the Ad Hoc Committee and those contained in the resolutions overlap in several instances and embrace various aspects of the same problem. Therefore, we have condensed what we consider to be the intent of the report and the hearing concerning the resolutions into the following proposed substitute resolution:

WHEREAS, the Congress of the United States passed the Kerr-Mills Law making it possible to provide a full program of medical benefits to the near needy aged on a federal-state matching fund formula; and

WHEREAS, the Legislature of the State of Illinois at its 72nd General Assembly did see fit to implement this program by enacting the Illinois State Medical Society sponsored and endorsed Senate Bill 197 and has appropriated the sum of 20 million dollars for this purpose; and

WHEREAS, it was the intent of both the Congress of the United States and the Illinois General Assembly that the health services thus made available to the medically indigent aged be adequate and realistic as evidenced by the broad range of services authorized by Public Law 86-778 (Kerr-Mills Law) and Illinois Senate Bill 197; and

WHEREAS, the administrative agency delegated to carry out this program, namely the Illinois Public Aid Commission, has seen fit to ignore and disregard the expressed legislative intent of the Congress of the United States and the specific direction of the Illinois General Assembly by unilaterally dictating con-

ditions for this medical program which are totally inadequate and insufficient to meet the needs of these people, and which are not uniform in their application; NOW THEREFORE BE IT

▶ RESOLVED, that the House of Delegates of the Illinois State Medical Society accept the recommendations contained in the last paragraph of the report of the special Ad Hoc Committee on the Kerr-Mills Program* and request all Illinois physicians to cooperate in the Aid to the Medically Indigent Aged program now in effect under the rules of the Illinois Public Aid Commission, as revised; and

▶ BE IT FURTHER RESOLVED, that the Illinois State Medical Society should immediately seek to improve the AMIA program by encouraging the inclusion of additional services authorized by the federal Kerr-Mills Law and the Illinois General Assembly which, in our opinion, should as a minimum include hospitalization; nursing home care; home care services; prescribed drugs; physicians' care, before, during, and after hospitalization; and necessary dental services; and

▶ BE IT FURTHER RESOLVED, that the AMIA program be broadened to include equal services for recipients in Cook County in order to fulfill the requirements of Title 1, Section 2 (a), of the federal law, which states: "A State plan for old-age assistance, or for medical assistance for the aged, or for old-age assistance and medical assistance for the aged must — (1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;" and thereby ensure that AMIA recipients in all counties of Illinois receive equal benefits under a tax-supported program; and

▶ BE IT FURTHER RESOLVED, that the Illinois State Medical Society insist that the Illinois Public Aid Commission comply with the provision of the law which requires negotiation with respect to payment for vendor services, and which, in the opinion of the Illinois State Medical Society, should be based upon a realistic value for services needed and rendered.

The Committee recommends the adoption of this substitute resolution as amended and moves the approval of this report as amended.

The Reference Committee acknowledges the assistance of staff and general legal counsel in the preparation of this report. The Chairman would especially like to thank the members of his committee for their diligent attention to duty, which required many hours of deliberation.

Charles Allison, M.D.
Andrew J. Brislen, M.D.
Julius M. Kowalski, M.D.
F. A. Tworoger, M.D.
E. W. Cannady, M.D., Chairman

*Last paragraph of Ad Hoc Committee Report:

"After carefully considering all of the many aspects of the problems confronting us, it is the considered opinion of the special Ad Hoc Committee that we should accept the revised program as it now stands for a trial period of six months. At the end of that period we should again meet with members of the Illinois Public Aid Commission to review the program, both from the standpoint of services provided and fees paid. In the intervening months we would hope that statistics on the program will be provided to us by IPAC in order that we might effectively evaluate the program."



AS I SEE IT FROM '360'

By Robert L. Richards
Executive Administrator

Teamwork and Individual Responsibility

Before writing for the new Journal, I followed the accepted procedure of researching what other association executives stated in similar publications. This in itself was a most enlightening adventure in reading journals which normally are passed over in the haste to get to other things in the office. My reward was the re-establishment of administrative ideals and a reconfirmation of faith in the democratic system of association activities. I am certain each person will know what I mean when I say I was extremely gratified for the opportunity to browse through the literature and find some ideas worth considering.

One of my favorite writers and associates — my tutor as a matter of fact — wrote in his annual report on the subject of administrative teamwork. Mr. Lester H. Perry, executive director, Pennsylvania Medical Society, stated:

"Teamwork, of course, is essential to organizational accomplishment. And teamwork requires cooperation, group thinking, some togetherness, and even perhaps a reasonable degree of uniformity. When teamwork, however, is equated with over-emphasis on conformity, this leads to apathy, then to stagnation, and finally to decadence."

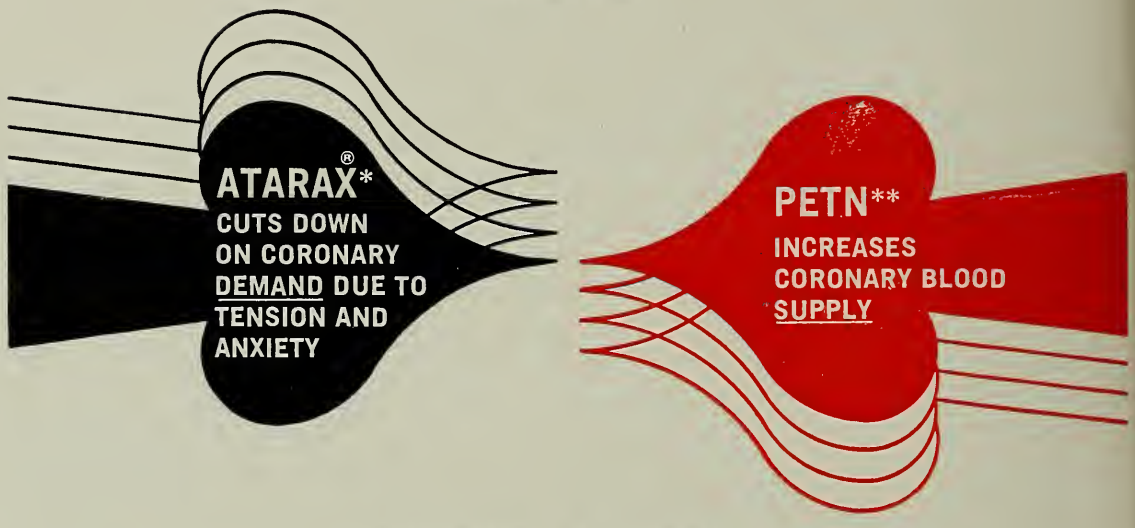
I trust that ISMS members will always think of our staff as a team; but if there is one thing we are not, it's conformists. As a matter of fact, our key staff members were selected because of their different training and backgrounds. Their unique experience and success indicated that they were dynamic thinkers rather than *yes* men in gray flannel suits.

Another colleague, Glenn B. Sanberg, executive vice president of the American Society of Association Executives, asked, "How is your organization structured to meet probable emergencies? . . . The history of free enterprise in America is replete with examples of organizations which have floundered because they were not prepared for sudden change . . . As association executives we have the responsibility not only to inform our members of dangers ahead but the opportunity to shore up the weak dikes as well."

In this respect our new staff has been structured to meet the probable emergencies of the future. In the past 16 months, it seems that crises have been the order of the day, but we have met them head on. As this is being written we are preparing for the special meeting of the House of Delegates to consider the administration of the Kerr-Mills Bill in Illinois. By the time this is published a policy will be established. This is what Mr. Sanberg meant. As I see it, the staff of ISMS is doing exactly what he recommends.

I know the average physician considers himself a strong individualist. But he should also reflect upon his responsibility to be a member of the team, although not necessarily a conformist. You too have a responsibility to advise your colleagues of dangers ahead and to shore up the dikes as well. Are you doing your part within your own county medical society? If not, perhaps you might ask, "Who is?"

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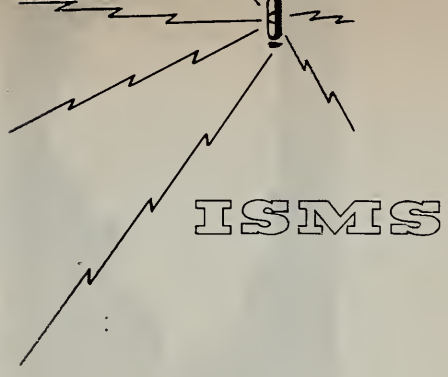
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1. Clark, T. E., and Jochem, G. G.: Angiology **11**:361 (Aug.) 1960.

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Announcements

Treatment of Mental Illness Series

Ego formation, overeating, and neurosis in marriage are among the topics in the 1961-62 season of a new annual lecture series named Treatment Situations sponsored by Forest Hospital, Des Plaines.

The series, centered on the fight against mental illness, was launched in October; the next lecture will be on November 22, with Dr. Hilde Bruch, clinical professor of psychiatry, College of Physicians and Surgeons, Columbia University, New York, discussing "Eating Disorders."

Dr. Avery Weisman, assistant clinical professor of psychiatry, Harvard Medical School, will speak on "The Dying Patient" on December 27.

All talks will be given at the hospital, and the series will run through June. Succeeding lectures will be announced in later JOURNALS.

The chairman of the program is Dr. Louis D. Steinberg, instructor in psychiatry, Northwestern University Medical School, and an attending psychiatrist at Michael Reese Hospital and Sherman Hospital, Elgin.

All physicians and other qualified workers in the mental health field are invited.

PG Course on Diabetes

"Diabetes in Review," the American Diabetes Association's 1962 postgraduate course, will run January 17-19, with the first and third day's sessions at Detroit's Statler Hilton and the second day's at the University of Michigan, Ann Arbor.

It is offered in cooperation with the University of Michigan Medical School, Wayne State University College of Medicine, Wayne County Medical Society, and the Michigan Diabetes Association.

The lectures will be "Fundamental Considerations," "Pathogenesis," "Insulin Assay-Antagonism and Acidosis," "Related Metabolic Problems," "Treatment of Diabetes Mellitus," and "Complications of Diabetes Mellitus." Dr. Charles Best will speak on "Present and Future Research Problems in Diabetes Mellitus."

Panel discussion topics are "Diabetes and Prediabetes—Pathogenesis and Prevention," "Problems in Management of Brittle Diabetes," and "Pregnancy and Diabetes."

Dr. Richard J. Bing, chairman of the department of medicine, Wayne State University, will give a luncheon talk on "Myocardial Metabolism in Diabetes."

For additional data write the Association at 1 E. 45th St., New York 17.

Doctors Invite Nurses to ASC Meeting

Surgeons, graduate nurses, and all related medical personnel are invited to the first of four 1962 Sectional Meetings of the American College of Surgeons in Los Angeles, January 29 through February 1. Headquarters hotel for physicians will be the Statler-Hilton and for nurses the Biltmore. This is the only four-day meeting scheduled for 1962 and the only one with a program for nurses.

Physicians' sessions will be in general surgery, obstetrics and gynecology, ophthalmology, otolaryngology, urology, and neurologic, plastic, pediatric, and thoracic surgery. There will be daily "How I Do It" nonoperative clinics, demonstrations by surgeons noted for specific techniques, 38 scientific papers, 28 panel discussions, 11 symposia, and films and industrial exhibits.

Comprising the nurses' program are panel discussions, symposia, films, hospital tours, and demonstrations, with discussions of mutual problems by nurses and physicians. Nurses are guests of the college and pay no registration fee.

President Dr. Ernest T. Smith, Santa Barbara,

will preside at the opening luncheon for Southern California Chapter Day.

The remaining 1962 meetings will be in Detroit March 5-7, Memphis March 26-28, and Washington, D.C., April 16-18.

$500 Surgical Research Paper

The Chicago Surgical Society announces its annual $500 Award for Surgical Research. Contestants cannot belong to the Society, and papers must be submitted by Feb. 1, 1962. Write the Secretary, Dr. Frederick W. Preston, 333 E. Huron St., Chicago 11, for details.

SK&F Foreign Fellowships Extended

The Association of American Medical Colleges announces the extension of the program of Foreign Fellowships for Medical Students, sponsored by Smith Kline & French Laboratories, Philadelphia pharmaceutical firm. Originally set up for a 3-year term to expire in 1962, it will be extended through 1963.

Fifty-nine students have already received grants, and the average time they spend abroad is about 12 weeks. Selections are made by an AAMC committee under the chairmanship of Dr. Robert A. Moore, president of the State University of New York, Downstate Medical Center, College of Medicine.

Students can obtain applications and instruction sheets from their deans; the closing date is Dec. 31, 1961. For additional information write the association at 2530 Ridge Ave., Evanston.

PRE-MED Premiers for Students

PRE-MED, a new journal for medical undergraduates prepared by pre-med students at Columbia College, New York, made its debut in October. The only journal of its kind on a national level, it will come out tri-monthly and be distributed free to 26,000 students at 280 colleges throughout the country.

According to editor-in-chief Armand R. Favazza, a senior at the college, PRE-MED was founded in response to a great decline in the application of highly qualified students to medical schools and is designed to intensify student interest in medicine as a career.

Articles will be written by experts in various fields of medicine; the premier issue contains an article by Dr. Luther Terry, U.S. surgeon general, on the U.S. Public Health Service, and another by Dr. Herman Hilleboe, commissioner of health, New York State, on The Challenge of Preventive Medicine.

The magazine has a board of commissioners of approximately 25 distinguished physicians throughout the country. Funds will come from a grant by Merck Sharp and Dohme pharmaceutical house.

Awards in Allergy

The Women's Auxiliary of the American College of Allergists will give two awards at the annual Congress of the American College of Allergists April 1, 1962, at the Hotel Radisson, Minneapolis.

The $150 Bela Schick Award will be made for the best paper from an associate member of the College, and the $250 Clemens Von Pirquet Award will go to the intern, resident or medical student with best paper on any aspect of allergy or its related fields.

Submissions must be before February 15; applications go to Dr. Mayer A. Green, Program Chairman, 6111 Jenkins Arcade, Pittsburgh.

Essay Prizes Offered

The Institute of Medicine of Chicago is offering its biennial Joseph A. Capps Prize of $500 for the most meritorious investigation in medicine or its specialties. The investigation may be also in the fundamental sciences, provided the work has a definite bearing on some medical problem.

Competition for 1961 is open to graduates of Chicago medical schools who completed their internship or one year of laboratory work within a period of five years prior to Jan. 1, 1961, excluding their terms of service in the Armed Forces. Manuscripts must be submitted to the Secretary of the Institute of Medicine of Chicago, 86 E. Randolph St., Chicago 1, not later than Dec. 31, 1961.

The American Thyroid Association, Inc. will present the Van Meter Prize Award of $500 to the essayist submitting the best manuscript of original and unpublished work on goiter, especially its basic cause. Studies may relate to any aspect of the thyroid gland in all its functions in health and disease and may cover

(continued on page 24)



Recognizing that the exchange of ideas is fundamental to medical progress, Lederle continues its Symposium program with the 10th year of scheduled meetings. Through these Symposia, sponsored by medical organizations with our cooperation, over 50,000 physicians have had the opportunity to hear and question authorities on important advances in clinical medicine and surgery. You have a standing invitation to attend any of these Symposia with your wife, for whom a special program is planned.

ANOTHER YEAR OF SYMPOSIA . . .

PROVIDENCE, RHODE ISLAND
Wednesday, November 1, 1961
The Colony Motor Hotel

HARRISBURG, PENNSYLVANIA
Thursday, November 9, 1961
The Penn Harris Hotel

JACKSONVILLE, FLORIDA
Sunday, November 12, 1961
The Robert Meyer Hotel

ALLENTOWN, PENNSYLVANIA
Wednesday, November 15, 1961
The Americus Hotel

SOMERVILLE, NEW JERSEY
Thursday, November 16, 1961
The Far Hills Inn

NASHVILLE, TENNESSEE
Wednesday, November 29, 1961
Meharry Medical College

EDINBURG, TEXAS
Saturday, December 2, 1961
The Echo Motor Hotel

WACO, TEXAS
Sunday, December 10, 1961
The Holiday Inn

Plans for 1962 already include the following Symposia, with more being arranged:

MOBILE, ALABAMA
Friday, January 5, 1962
The Admiral Semmes Hotel

ST. PAUL, MINNESOTA
January 8, 1962
The Hotel Lowry

PORTLAND, OREGON
Wednesday, January 24, 1962
The Sheraton-Portland Hotel

ANCHORAGE, ALASKA
Saturday, February 24, 1962
The Westward Hotel

WINCHESTER, VIRGINIA
Wednesday, March 14, 1962
The Lee-Jackson Hotel

SIOUX CITY, IOWA
Thursday, March 15, 1962
The Sheraton-Martin Hotel

SPOKANE, WASHINGTON
Saturday, June 2, 1962
The Davenport Hotel

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Announcements *(continued from page 22)*
either clinical or research investigations. Essays should not exceed 3,000 words and should be submitted not later than Jan. 1, 1962.

For details write Dr. Theodore Winship, Secretary, 430 N. Michigan Ave., Chicago 11.

AMA Meeting Highlights Filmed

Medifilm Report III, presenting highlights of the American Medical Association's annual meeting in New York City, has been made available to medical and allied groups by Schering Corporation in cooperation with the AMA Department of Medical Motion Pictures and Television.

The 33-minute, 16 mm. black and white sound film features scientific exhibits, lectures, and panel discussions. Host-narrator is Dr. Jeff J. Coletti, Old Westbury, N.Y. Of special interest is a demonstration of external cardiac massage at the 1961 Gold Medal Award exhibit. A mannikin is used to show the actual technique of closed chest cardiac massage.

Other subjects covered are office management of varicose veins, electrical anesthesia, new concepts in diabetes, rubella in pregnancy, polycystic ovaries, the anxious outpatient, allergic reactions to drugs, cine coronary arteriography, and part time medical mission work.

In conclusion, Dr. E. Vincent Askey, outgoing AMA president, speaks on teamwork in medicine, the theme of the 1961 convention.

Interested county medical societies may obtain a copy by writing the AMA at 535 N. Dearborn St., Chicago 10, or to the Audio-Visual Department, Schering Corporation, Union, N.J.

SOCIAL SECURITY POLL — Preliminary Report

Balloting in the poll of Society members on social security coverage for physicians continues with scattered returns still being received at Society headquarters. On November 1, the vote on the key question, No. 3, "Are you in favor of compulsory social security coverage for all physicians?" was as follows:

Area	In Favor	Opposed	No. of Votes Cast
Cook County	1,839 (52%)	1,687 (48%)	3,526
Downstate	951 (37%)	1,614 (63%)	2,565
Total	2,790 (46%)	3,301 (54%)	6,091

The 6,091 votes cast represent opinions from 61 per cent of the membership. A final and detailed analysis of the vote, including age distribution and county society membership, will be published in the next JOURNAL.

LOOK FOR MORE ON THE SOCIAL SECURITY POLL IN THE DECEMBER ILLINOIS MEDICAL JOURNAL

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POTASSIUM PENICILLIN V

BECAUSE potassium penicillin V (Compocillin-VK) offers excellent absorption[1,2,3,4]—fast, predictable levels of antibacterial activity enter the blood stream and quickly reach the site of infection. *Absorption takes place high in the digestive tract and is virtually unaffected by gastric media.*

Antibacterial levels are so predictable that, in many cases, *Compocillin-VK may be prescribed in place of injectable penicillin.* This is especially appreciated by younger patients and—as you know—oral administration is considered far safer than injectable.

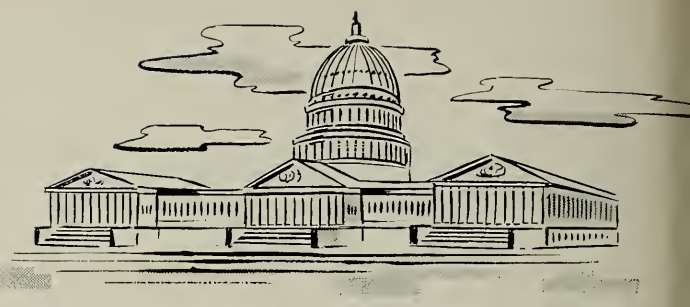
Compocillin-VK is well tolerated and may be used in treating mild, severe, and in high dosage ranges, even critical cases involving penicillin-sensitive organisms. It comes in stable, palatable forms for every patient—every age.

There are tiny, easy-to-swallow Filmtab® tablets—125 mg. and 250 mg. (200,000 units and 400,000 units), a tasty, cherry-flavored suspension (each 5-ml. teaspoonful contains 125 mg.) and two combinations (Filmtab and suspension) with the triple sulfas. Depending on severity of infection, dosage for Compocillin-VK is usually 125 mg. or 250 mg. three times a day. Won't you try Compocillin-VK?

1. R. Lamb and E. S. Maclean, Penicillin V—A Clinical Assessment After One Year, *Brit. M. J.*, July 27, 1957, p. 191-193. 2. J. I. Burn, M. P. Curwen, R. G. Huntsman and R. A. Shooter, A Trial of Penicillin V, *Brit. M. J.*, July 27, 1957, p. 193. 3. J. Macleod, Current Therapeutics, *The Practitioner*, 178:486, April, 1957. 4. W. J. Martin, D. R. Nichols and F. R. Heilman, Observations on Clinical Use of Phenoxymethyl Penicillin (Penicillin V), *J.A.M.A.*, p. 928, March 17, 1956.

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The Month In Washington

Campaign Accelerated Against Medical Quackery

The American Medical Asociation and the federal government declared all out war on medical quacks and charlatans who bilk the sick and gullible of hundreds of millions of dollars each year through useless gadgets, phony nostrums, fake reducing pills, and the many other gimmicks of the medicine show trade.

The campaign was launched at the First National Congress on Medical Quackery, under joint sponsorship of the AMA and the U.S. Food and Drug Administration, Oct. 6-7 at the Sheraton-Park Hotel in Washington.

Among the keynote speakers were two top officials in President John Kennedy's cabinet, Secretary of Health, Education and Welfare Abraham A. Ribicoff and Postmaster General J. Edward Day. Leonard W. Larson, M.D., president of the AMA, and Oliver Field, Director of the AMA Department of Investigation, spoke for organized medicine.

Others on the program included Herbert J. Miller, assistant U.S. attorney general in charge of the criminal division; George P. Larrick, commissioner of the FDA, and Paul Rand Dixon, chairman of the Federal Trade Commission. Other speakers included representatives of the American Cancer Society, the Arthritis and Rheumatism Foundation, and the National Better Business Bureau. C. Joseph Stetler, director of the Legal and Socioeconomic Division of the AMA presided at the meeting.

Many state and county medical societies from throughout the nation sent representatives to the Congress. They carried back to their societies plans for cooperation with enforcement agencies at the local level and for a step-up of public education on the subject in an accelerated campaign against quacks.

Highlights of the talks included:

Larson: "We must educate the public thoroughly and effectively. We must wage psychological as well as scientific warfare. We must not only prove the worthlessness of quackery, but we also must establish confidence in sound medical and health care.

"Speaking for the American Medical Association and our 180,000 physician-members, I pledge our efforts to the final eradication of quackery and all its minions and satraps."

Ribicoff: "The total cost of unnecessary or dangerous medications in this country probably exceeds $1 billion each year. Much of this expense is to men, women, and children who dearly need this money for good medical care or for other necessities of life.

"But quackery's costs in dollars only introduces the story. In terms of false hopes raised, in terms of ugly delusions fostered, in terms of tinkering with human life itself, the cost cannot be measured. The quack flirts with disaster. He challenges the sixth Commandment: 'Thou shalt not kill.'"

Larrick: "The most widespread and expen-

sive type of quackery in the United States today is in the promotion of vitamin products, special dietary foods, and food supplements. Millions of consumers are being misled concerning their need for such products. Complicating this problem is a vast and growing 'folklore' or 'mythology' of nutrition which is being built up by pseudoscientific literature in books, pamphlets, and periodicals. As a result, millions of people are attempting self-medication for imaginary and real illnesses with a multitude of more or less irrational food items. Food quackery today can only be compared to the patent medicine craze which reached its height in the last century. Especially disturbing is the tendency shown by some big and hitherto respected food concerns to use quackery in their sales material."

Dixon: "Properly drafted and administered, legislation giving the Federal Trade Commission power to issue temporary cease-and-desist orders would, while observing all the requirements of due process, make it possible to protect the public interest more adequately in many areas.

"Although in the case of food, drug, and cosmetic advertising, the Commission can . . . apply to district courts for temporary injunctions, it would be much more efficient for the Commission itself to issue temporary orders in those cases as well as in others."

Day: "The peddling of fake medical cures is the most prominent fradulent activity conducted through the U. S. mails today. This huge 'industry' — and it has grown to that extent — is so prevalent and so widespread that it taxes the manpower of the Postal Inspection Service to the utmost in trying to bring the perpetrators to justice.

"We are doing everything we can to make more of our inspectors available to work on cases of this nature, to the extent it will not jeopardize enforcement in other fields."

Dr. L. Henry Garland, American Cancer Society: "The charlatan is in business to make money and he does so by offering *hope*. He tends to be courteous, optimistic, easily understood by the laymen, and confident that cure can be obtained. His patient does not care that the method used is a secret one, that the testimonials are largely fraudulent, or that the 'doctor' may not even be licensed. All he knows is that he is being reassured and treated by someone who seems to be interested in him as a person.

"If it is granted that the causes of charlatanism are . . . diverse, it seems obvious that control must be equally diverse — composed of the difficult and slow triad — public education, professional education, and continued research in cancer prevention."

Dr. R. W. Lamont-Havers, Arthritis and Rheumatism Foundation: "That this is a large problem is indicated by the estimated 250 million dollars a year that arthritic victims spend upon unproven and misrepresented products in a vain attempt to obtain unrealizable relief from their suffering. Not all of these products are quackery in the sense of being useless. Some contain active ingredients — usually salicylates, or apparatus such as vibrators, but are promoted with such misrepresentation of effects that the arthritic fully expects results beyond the capabilities of the drug. Others are outright quackery and include such popular items as alfalfa tea, uranium pads, honey, and vinegar, etc. Of particular concern are the widely advertised so-called 'clinics,' chiefly in Missouri and Florida."

Field: "We would like to envision the time when we can cease to worry about the medical quack. But it's going to take an awful lot of doing. The Food and Drug Administration, the Post Office Department, the Federal Trade Commission, and the food and drug groups of many states of the Union cannot do the job alone. It takes a program which seeks to acquaint the public with the problem and swings into action quickly when there is a threat to the community or to the nation at large. This takes the help of all interested people — consumer groups, educational groups, religious organizations, and, most of all, those responsible for the education of the American youth. . . . The emphasis should be on letting the public know, strengthening the laws where necessary, but most of all, providing a means of distinguishing between the legitimate medical practitioner and the one who pretends to be one."

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Daily exposure to colds and contagion can't be controlled, but Robitussin does a superior job of checking the frequency and severity of the coughs that result from it. Remarkably safe to coughers of all ages, Robitussin produces a significant, prolonged, expectorant effect by tripling* the volume of respiratory tract fluid (RTF). Increased RTF helps loosen congestion by liquefying sputum and by enhancing the action of the bronchial and tracheal cilia. Thus, a Robitussin-treated cough is not abruptly or temporarily suppressed, but ends itself naturally by becoming more productive, cleansing the airways of irritating mucus and exudates. And most important, Robitussin tastes good to children and adults alike! Robitussin® is glyceryl guaiacolate, 100 mg. per 5 cc. dose; Robitussin® A-C adds prophenpyridamine maleate 7.5 mg., and codeine phosphate 10.0 mg. per 5 cc. dose (exempt narcotic).



PHARMACEUTICAL RESEARCH 1878

*Cass, L. J., and Frederik, W. S., Am. Pract. Dig. Treat., 2:844, 1951.

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The ILLINOIS Medical Journal

Official Journal of the Illinois State Medical Society

Volume 120, No. 5 November, 1961

The Incompetent Internal Os of the Cervix

Jack D. Brodsky, M.D., and Carl Greenstein, M.D., *Champaign*

Much has been written about the diagnosis and therapy of the incompetent internal os of the cervix. Patients with habitual second trimester abortion may be treated prophylactically during gestation or surgically during the nonpregnant and pregnant state.[1-10] Many relatively infertile women are capable of delivering viable babies when the cervical factor is treated adequately.[11-13] Diagnostic criteria for this entity vary from author to author.[4,14,15] Many modifications[9,14,16-19] of the original surgical techniques[1,2] have been developed especially for use during pregnancy. The conclusions drawn from the small numbers of patients in each of the papers cited as well as in the current paper are faulty in that they are drawn on rather small numbers of patients. Consequently, a critical statement has been made without adequate statistical evidence.

Presented at the annual meeting of the Illinois Obstetrical and Gynecological Society in Chicago, May 15, 1961.

Diagnosis

The chief factor in determining the diagnosis of incompetent internal os of the cervix is the history of repeated abortions, especially during the second trimester of pregnancy. They are usually characterized by a relatively silent bulging of the amniotic membranes through the external os when a vaginal speculum is introduced for examination. Rupture and a relatively painless expulsion of the fetus eventually occur, usually preceded by slight reddish or brownish spotting and a marked increase in cervical secretions. The diagnosis, of course, is made early if a vaginal speculum is introduced.

Examination before pregnancy usually reveals no obvious abnormality. However, exploration of the cervical canal with a Hegar dilator up to No. 7 in diameter meets with an unusual lack of resistance at the level of the internal os. With a Hegar dilator within the canal, palpation of the external circumference of the cervix at the level of the internal os often will demonstrate a defect anteriorly or laterally in the

internal os. This point of defect is the site of previous injury or lacerations of cervical wall healed with a wide scar. Examination by the palpating finger at the level of the internal os immediately postabortal will often reveal the same finding from within the cervical canal.

Confirmatory x-ray studies of the cervix at the level of the internal os may be done if this abnormality is only slight, since other abnormalities may cause habitual abortions. The introduction of the intrauterine balloon catheter distended with a radiopaque medium will clearly reveal the defect if it exists.

Principles of Therapy

Treatment is directed at closing the gaping internal os. This can be accomplished in the nonpregnant woman by the Lash cervical repair operation.[2] During pregnancy the Shirodkar operation[1] or one of its modifications is used. Strips of ox fascia, homologous fascia, and various types of nonabsorbable suture have been used with some degree of success. One of the most recent modifications is the use of the Mersilene® one-quarter inch tape for circumscribing the cervix through submucosal tunnels, anchored either posteriorly or anteriorly, with the cut ends remaining long enough for easy identification and removal at 38 to 39 weeks. As the removal procedure is a minor one, it can be done under local infiltration anesthesia. This operation can be repeated for future pregnancies. We have on occasion allowed the Mersilene ligature to remain in situ and have delivered the patient by caesarean section; on other occasions we have removed the ligature and allowed the patient to go into labor spontaneously. Both measures have been successful.

Postoperatively, the patient is treated with sedatives and progesterone until all signs of abnormal uterine irritability have passed. When the defect is demonstrated before a pregnancy, the Lash cervical repair is performed. Any cervicitis must be cured before the operation. Surgery is done at or prior to midcycle, although on one occasion is was performed immediately after termination of pregnancy.

The surgical technique consists of reflection of the bladder by a semicircular incision through the vaginal wall at the anterior reflection of the vaginal wall over the portio vaginalis uteri. The bladder is dissected free from the anterior cervical wall up to or beyond the level of the internal os. The dilator is placed within the cervical canal so that the extent of the cervical defect can be determined by the palpating finger. The defect is excised in a longitudinal wedge so that the full thickness of the cervical wall can be demonstrated on either side of the defect. The wound is then closed with interrupted No. 1 catgut suture, preferably in two layers, or with interrupted tantalum wire sutures. During this closure, the dilator is left in place to avoid producing any stenosis of the cervical canal or to prevent inadvertently passing any of the sutures through its posterior walls. The dilator is withdrawn gradually as the sutures are tied from the proximal to the distal. Immediately following the closure of the cervical canal, a No. 5 Hegar dilator will fit snugly. The vaginal wound is then closed with interrupted No. 0 chromic catgut suture, and the patient is placed on postoperative antibiotics for three to four days. Patients are ambulatory within 24 hours and discharged within five to six days. Contraception is suggested for the next three to six months until the scar heals completely.

Case Reports

We present eight cases seen over a five-year period; only five are reported in detail herein. One case was lost to follow-up. The other two cases were mild enough to be treated medically.

Case 1. Mrs. R. D., age 30, in 1950 had delivered a 4 lb. 12 oz. female infant at 35 weeks after a 12-hour labor with aid of forceps and episiotomy under general anesthesia. In 1952 the patient aborted spontaneously at two months and then bled for three weeks. In 1953 she aborted identical twins at four and a half months and was reported to have a puerperal sepsis. In March, 1954, she again aborted spontaneously, and after four weeks had a dilatation and curettage. In April, 1955, she had a spontaneous rupture of membranes at four and a half months' gestation and aborted three days later. She required a D and C for retained placenta and three weeks later following hemorrhage was curetted for retained secundines.

The patient was first seen by us for preg-

nancy on Sept. 21, 1955. The corpus was markedly retroverted but mobile, and a Smith-Hodge pessary was inserted to anteflex the uterus. Lutrexin®, Cyclogesterin®, and C.V.P.® were prescribed. The pregnancy proceeded uneventfully for four and one-half months when speculum examination revealed that the cervix was dilated two or three centimeters with the membranes protruding from the cervical os. The patient was hospitalized, but in spite of bed rest, progesterone, and sedation, she miscarried spontaneously a 1 lb. 6 oz. female infant that lived only one hour and 40 minutes. Palpation of the cervical canal revealed the defect in the anterior quadrant of the internal os. Three months later at a cervical plastic operation a longitudinal strip of cervix approximately 1.5 centimeters wide was excised and the cervix closed with tantalum wire sutures.

About 20 months later, the patient conceived and was again placed on Lutrexin and Delalutin® every two weeks. At four and a half months' gestation she was admitted to the hospital with a diagnosis of threatened abortion. Under complete bed rest and increased progesterone therapy the uterine irritability ceased; but the cervix appeared to be more effaced, although not dilated. A double "0" black silk ligature was placed around the cervix at the level of the internal os, and two days later she was discharged from the hospital. One week later she was re-admitted because the ligature had slipped off the cervix, and she had begun to cramp and bleed moderately from the cervical os. The cervical ligature was replaced, and 500 cc. of whole blood was given to replace the blood loss. She was hospitalized nine days.

On April 25, 1958, at five and a half months' gestation, the patient was again admitted to the hospital because of increased vaginal bleeding, lower abdominal cramping and severe backache. Again, after hospitalization and considerable therapy, symptoms receded, 500 cc. of whole blood was given to replace the insidious blood loss, and she was discharged on May 4. On May 7 she was admitted for a more massive hemorrhage. An immediate low cervical caesarean section was performed, and an immature previable female was delivered that lived only a matter of minutes. The cause of hemorrhage was found to be a central placenta previa. The patient was in extreme shock throughout the procedure; blood was administered through four different routes, and Solucortef® was administered intravenously during the procedure. The patient appeared to improve slightly following the caesarean section, but in spite of an intrauterine pack, intrauterine Pitocin® and intravenous Ergotrate® she continued to hemorrhage. Two hours following the caesarean a supracervical hysterectomy was performed as a lifesaving procedure. The patient made a slow recovery and required a total of 14 pints of blood during her hospitalization. To this day, she still retains the cervical stump with the wire ligatures.

Case 2. Mrs. P. F. was first seen by us in 1955 at the age of 38. In 1954 after a 30-hour labor induced at eight and one half months for toxemia she was delivered by forceps of a stillborn large female infant. Examination revealed a markedly scarred, relaxed perineum, a second degree cystocele, extensive lacerations of the cervix at 6 and 12 o'clock, considerable endocervicitis, and an ectropion of the anterior lip of the cervix. In August, 1955, the patient had a Manchester cervical plastic operation for repair of this widely gaping cervix. One year later she conceived but aborted spontaneously at six to seven weeks' gestation. Finally in June, 1958, at the age of 41, the patient ruptured membranes at 36 weeks' gestation, developed a sudden pre-eclamptic toxemia, fetal distress, and was delivered by caesarean section of a 5 lb. 3½ oz. male that survived.

Case 3. Mrs. J. H., 23, was first seen by us in August of 1956. She had one living child and subsequently aborted spontaneously at five months, at five and one-half months, and the third time at four and a half months. Radiographic examination of the cervical canal revealed a defect of the anterior wall, and in March, 1957, a cervical plastic operation was done using chromic No. 1 catgut. Nine months later the patient conceived again and progressed uneventfully with the prophylactic use of Norlutin® and C.V.P. daily, until at four and one-half months she again aborted spontaneously a macerated fetus. On postabortal examination it was suggested that further cervical radiographic studies be done; however, she has not returned for any future studies.

Case 4. Mrs. P. L., a 21 year old gravida 4, had a history of one living infant delivered spontaneously at seven months and weighing 3 lb. 3½ oz., but two other late abortions preceded this pregnancy. The first one in August, 1957, terminated with the silent rupture of membranes at five months; the second in March, 1958, with the silent prolapse of the amniotic sac aborted rapidly thereafter at six months. She was first seen by us in June, 1960, during her fourth pregnancy. The cervical canal appeared to be gaping even in very early pregnancy, and dilatation of the cervix began at four and a half months. She was admitted to Mercy Hospital, Urbana; a Mersilene ligature was placed around the cervix at the level of the internal os, and the patient was discharged from the hospital 48 hours later. When she was eight and a half months pregnant, the ligature was removed. Within 24 hours she went into spontaneous labor and delivered a 5 lb. 12 oz. female infant that survived.

Case 5. Mrs. D. B. was first seen by us in December, 1959. Three and one-half years previously after a five-hour labor she had delivered spontaneously, under saddle-block anesthesia, a 3 lb. 3 oz. male. Two and one-half years prior to the date of our examination she had delivered at seven months a male infant in a compound presentation. The delivery was reportedly traumatic, and the child died after 15 hours. The patient became pregnant in November, 1959, and on her first examination no cervical abnormalities were noted. The corpus appeared to be retroverted[4] but was readily replaced. When the patient was three months pregnant, she was hospitalized because of spotting and cramping. This receded after four days. Daily brown spotting began at five months, and when she finally reached six months, speculum examination for the first time revealed effacement and beginning dilatation of the cervix with the membranes protruding through the external os. She was immediately hospitalized, and a Mersilene ligature was placed around the cervix at the level of the internal os. Three days later she was discharged and was followed with frequent visits at the office. It was arbitrarily decided to leave the Mersilene ligature in place. At 38 weeks, a 5 lb. 13 oz. female infant was delivered by low cervical caesarean section, and it survived.

Discussion

This series of eight cases is statistically very small and represents only 0.3 per cent of our obstetrical cases over the five-year period. Yet, it is truly distressing to the patient suffering from this condition because of the resulting infertility. More frustrating than the inability to conceive is the inability to proceed to term. We have approached this problem in various ways and have met with varying results depending on the degree of incompetence of the cervix. In the mild or questionable incompetence, apparently therapy with bed rest and the more powerful synthetic progesterone-like substances aid the patient in progressing to term. In the more outspoken incompetence, ligation of the cervix at the level of the internal os during pregnancy, or a repair of the cervix between pregnancies is mandatory. After repair it is our impression that these patients fare better if delivered by caesarean section. The Mersilene ligature may be left in place without any apparent foreign-body reaction and may be used to prevent incompetence during future pregnancies.

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Nutritional Habits of Midwestern Workingmen

Oglesby Paul, M.D., and
Anne MacMillan, B.Sc.

For the past four years we have been conducting a health survey of approximately 2,000 men in the age group 40-55 employed in a large industry (Hawthorne Works, Western Electric Co., Inc.) in Chicago. Among the factors under surveillance has been diet, and information has been obtained which may be of some interest as indicating the food habits and dietary intake of such a group of industrial workers in the Midwest. Such a survey has some application to current thinking in relation to cardiovascular disease.

The dietary data has been secured chiefly by interview of each man with a dietitian. The first year each interview took about one hour, but a shorter time was required in subsequent years. Validation of the method has employed re-interview with a second dietitian, and comparison with a one-week's food intake recorded in booklets by the men themselves. Questionnaires were mailed each year to the wives of the participants to obtain supplementary information on products used in cooking and on cooking methods. Wives selected by sampling methods have also been interviewed.

The physicians and dietitians working in the health survey gave no advice on diet or weight change, and prescribed no medication.

Of the subjects' patterns of eating, it can be said, in approximate terms, that:

a. 97.4% eat breakfast
b. 3.9% omit lunch
c. 16.7% eat a heavy noon meal and a heavy evening meal
d. 7.8% eat a heavy noon meal and a light evening meal
e. 71.6% eat a light noon meal and a heavy evening meal
f. 49.0% eat midmorning snack
g. 28.0% eat midafternoon snack
h. 63.0% eat late evening snack
i. 10.0% drink only beer in the evening

We have been interested in the general character of the diet also, not just in its components. Thus, it may be said that most of our subjects were big meat eaters, used dairy products (except milk) and soups generously, and tended to have a low intake of leafy vegetables and fruits. Bread and other cereals also were used generously. In average terms, subjects ate meat 13 times a week; milk, 8-10 glasses a week; eggs, 7 a week; cheese, 4 ounces a week; butter, 11 ounces a week; ice cream, ¾ pint a week and a similar quantity of cream, and soft drinks on an average of 6 ounces a day. Fruits and vegetables were consumed on an average of 1½ servings of each a day, bread on an average of 40 slices a week, plus 2 to 3 helpings of

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This study has been supported in part by grants from the American Heart Association, Chicago and Illinois Heart associations, and the United States Public Health Service.

While the Nutrition Committee of the Chicago Heart Association is sponsoring this article, the opinions expressed are those of the authors, and do not necessarily represent the official view of the committee.

pastry a day. An average of 6 helpings of soup was also taken in weekly.

In terms of caloric intake the average daily consumption of the group was 3,190 with a range of 807 to 17,159 calories.

Much attention has recently been concentrated on the type of fat consumed and its relation to atherosclerosis. Since, as we have indicated, the group in our study consumed generous amounts of meat and dairy products, it is not surprising to find that the average amount of animal fat taken in per day per man was 118 grams or 33.3 per cent of the total calories. On the other hand, the vegetable-fat intake averaged 34 grams per day or 9.6 per cent of total calories. The intake of saturated fatty acids averaged 59 grams per day or 33.8 per cent of the total fat consumed. Polyunsaturated fatty acids averaged 83 grams per day or 54.6 per cent of the total fat consumed.*

Carbohydrate intake averaged 305 grams per day or 38.2 per cent of the total calories, and protein intake averaged 118 grams per day or 14.8 per cent of the total calories.

For 6.6% of the fats consumed, the exact composition is unknown.

The average daily intake of minerals and vitamins was found to be:

Calcium	1.09	grams per day
Phosphorous	2.34	grams per day
Iron	17.3	milligrams per day
Vitamin A	12,409.0	I.U. per day
Thiamin	1.67	milligrams per day
Riboflavin	2.53	milligrams per day
Niacin	22.9	milligrams per day
Vitamin C	104	I.U. per day
Vitamin D	198	I.U. per day

The second year of the study showed that some change in food intake had occurred in 20 per cent of the men. Approximately 41 per cent of these changes were attributed to reduction diets and 31 per cent to diets low in animal fat.

In the third year of the study, changes in food intake had occurred in 12 per cent of the men. Approximately 44 per cent of these changes were attributed to reduction diets and 21 per cent to diets low in animal fat.

However, it should be said that, in the vast majority, the changes reported were modest and resulted in only slight differences in caloric and fat intake.



According to the ISMS Constitution . . .

Every Registered Physician holding the title of Doctor of Medicine or its equivalent, who resides in the jurisdiction of a component society, and who is of good moral character and professional standing and a citizen of the United States, shall be eligible to membership. The component county society shall be the sole judge of the qualification of its members, subject only to the stipulations contained in the Constitution and Bylaws. *Chapter XI, Section 4.*

Safety and Efficacy in the Prophylactic Management of Tetanus

Roy Patterson, M.D., *Chicago*

The etiologic agent of tetanus, *Clostridium tetani*, is present in the gastrointestinal tract of man and animals and in the soil, particularly in populated areas. The organism has been isolated from the human oral cavity and body surface and from the dust of homes. The almost universal presence of its spores constitutes a threat following any injury.

The therapy of tetanus is difficult, and the mortality rate is high. The only effective management of the disease depends on the protection of the patient by antibodies against tetanus toxin. They can be produced in man before an injury by active immunization with tetanus toxoid; or preformed antibodies in antiserum produced in animals can be given to the patient (passive immunization) at the time of injury. Tetanus antitoxin prepared from horse serum is the most commonly used. Tetanus toxoid is effective when utilized as fluid toxoid, precipitated toxoid, or toxoid in combination with multiple antigens including pertussis, diphtheria, and poliomyelitis vaccines.

The greater effectiveness of active immunization with toxoid was shown in World War II following the routine immunization of American troops; there were only six cases of tetanus per million injuries, and some of these cases had not received the optimum immunization procedures. In contrast, during World War I, when antitoxin from horse serum only was used in wounded soldiers, the incidence of tetanus was 170 times that of World War II.[1]

Certain observations are important in dealing with the problem of prevention of tetanus in a safe and effective manner. Fifteen per cent of a series of cases of tetanus in England and Wales occurred after trivial wounds; an additional 35 per cent occurred in patients with no history of injury.[1] Thus in 50 per cent of the cases of tetanus there can be no adequate prevention of the disease by horse antitetanus serum, because these very minor injuries will almost never be seen by a physician. In addition, tetanus may occur in spite of the administration of horse serum. The usual dose of 1,500 units of antitoxin is not considered adequate by some, and 5,000 units have been recommended in any case where horse serum appears indicated.[2] The administration of 1,500 units of horse antitoxin in man results in 0.1 unit of antitoxin per milleliter of serum, lasts for 10 to 11 days and disappears from the body in 21 days,[2] probably sooner in some cases. This disappearance is the result of catabolism of horse gamma globulin by man and probably

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Presented at the 121st Annual Meeting of the Illinois State Medical Society in Chicago, May 16, 1961.

elimination of the horse gamma globulin after sufficient time has elapsed for the development of a human antihorse serum protein antibody response to the foreign serum protein. On the basis of animal experiments it could be expected that a second injection of horse serum into man shortly after administration of the first injection would be followed by prompt elimination of the horse antitoxin.

Tests to Determine Sensitivity

The problems that occur as a result of the administration of horse serum antitoxin are significant. There is one death from every 50,000-100,000 injections of horse serum, about 35 deaths per year in the United States. The risk of disability from an injection of horse serum is 265 times greater than the risk of tetanus from a wound.[3] In addition to fatal anaphylactic shock, other reactions occur, such as serum sickness. The most serious reactions are myelitis, polyarteritis nodosum, pericarditis, myocarditis, and encephalopathy.

A patient with no previous history of sensitivity to the foreign serum may develop serum sickness after the first injection. If a patient gives a history of previous injection of horse serum or allergic symptoms after exposure to horses, the possibility of either an accelerated serum sickness reaction or an anaphylactic type of reaction is much greater. Each must first be evaluated by history and skin tests. While various authorities differ, generally, a skin test dose of .05 cc. of a 1:10 dilution of serum is advised; however, this dose is not without risk in a highly sensitive individual. If the patient gives a history of sensitivity to horses or has had a previous injection of horse serum, initial scratch-testing should be done with a 1:100 dilution of horse serum followed by testing with a 1:10 dilution if the first test is negative. If both scratch tests are negative, intracutaneous tests follow, first with the 1:100 serum dilution, then with the 1:10 dilution.

When a patient has a definite sensitivity and a positive skin test to horse serum, the first choice of management is to use bovine antitetanus toxin, again using appropriate skin tests prior to injection. If a patient is sensitive to both horse and bovine antisera, desensitization is recommended by some.[4] However, there is some controversy over this approach; some physicians believe that foreign serum should never be administered to a sensitive patient. It may not be possible to treat a patient who has the true anaphylactic type of sensitivity with a sufficient amount of antiserum to be effective. Furthermore, there is evidence based on experimental work in animals that suggests that circulating antitoxin antisera might be rapidly eliminated and destroyed in the sensitive individual and, therefore, be ineffective as prophylaxis against tetanus in the sensitive individual. With these factors in mind, it is evident that the best approach in a serum-sensitive patient would be to give human antitetanus toxin. Unfortunately, this is not presently available for general use.

When by skin test the patient is proved to be sensitive to horse and bovine serum and the nature of the wound is such that antitoxin appears indicated, it is advisable for the physician to have the opinion of at least one, preferably two, other physicians. This has value both for arriving at the proper course of management and for protecting the physician in the management of a case with potential medicolegal complications. In any case, there must be adequate wound care, and it is thought that there is a significant prophylactic value in inhibiting growth of the organism by antibiotics administered at the time of injury.[2]

Active Immunization Preferred

Because of the danger of horse antiserum and its occasional ineffectiveness, there has been greatly renewed interest in efforts to protect the general population by active immunization with tetanus toxoid. It is safe, easy, and effective. Adequate prevention of tetanus can subsequently be attained when necessary by booster immunization. Present evidence indicates that a booster immunization of tetanus toxoid given ten years after primary immunization will produce adequate levels of antitoxin at the time of an injury in a majority of patients.[1] Booster doses are best administered at four to five year intervals with an additional booster dose at time of injury.[5] The basis of this adequate immunization is in the hands of the family physician who can urge immuniza-

tion of his patients and encourage programs that are being initiated by some city and county medical societies.

Management of Sensitivity Reactions

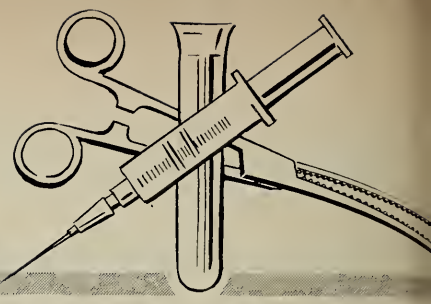
Every physician must be prepared for emergency therapy of reactions to injection of materials such as foreign serum and penicillin. Anaphylactic shock may occur within seconds or minutes, and at times before the physician has finished injecting the foreign material. He has no time either to read about the treatment or to hunt through various drawers for drugs and equipment. He should have both a method of treatment clearly in mind and the necessary material ready for use in an easily accessible place. A method of treatment, based on experimental work in animals and on clinical experience, is as follows: An injection should be given in an extremity whenever the material may cause an allergic reaction, so that a tourniquet may be applied above the site of injection to slow absorption if a reaction develops. At the first indication of any symptoms after an injection, a tourniquet is placed above the site of injection to slow absorption, .3 cc. of 1:1,000 epinephrine is injected intramuscularly in the opposite arm, and the same amount of epinephrine is injected into the original site of injection to slow absorption of the causative agent. The epinephrine can be repeated every 10 to 15 minutes. The initial epinephrine should be followed immediately by the intravenous injection of an antihistaminic agent such as 50 mg. of Benadryl®. Administration of oxygen should be started as soon as possible. Further management depends on patient response. If the patient is in shock, a vasopressor agent such as Levophed® in 5 per cent dextrose in water should be administered by intravenous drip to maintain blood pressure. If laryngospasm is present, a tracheotomy is indicated. Some patients may have significant bronchospasm as a part of the reaction, and the slow, cautious administration of 250 mg. of aminophylline intravenously is indicated. In the absence of bronchospasm, aminophylline is probably not indicated. Contrary to occasional usage, there is no evidence that adrenal cortical steroids are the medication of choice, and they should not be given prior to the epinephrine or antihistamines since they only delay the administration of these more appropriate agents.

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The Master's Test

A critical appraisal of the "2-step" electrocardiogram exercise test indicates that it cannot be used for prognostication in the individual case. It does help to delineate a group in whom there appears to be an increased incidence of coronary artery disease. It has been our practice to use the abnormal electrocardiogram exercise test as a motivating factor in health counseling as regards weight reduction and elimination of excessive smoking. This becomes particularly important for those persons with a family history of degenerative disease or who themselves have diabetes mellitus or hypertension or who exhibit elevation of blood uric acid and cholesterol. It should be emphasized that these abnormalities are not necessarily diagnostic of coronary artery disease, and proper caution is to be observed in discussing such findings with lay persons. *S. S. Franco, M.D., et al. Periodic Health Examinations: A Long-Term Study, 1949-1959. J. Occupat. Med. January 1961.*



Clinical Surgical Conferences

Cook County Hospital

Palliation for Solid Tumors

Moderator: ROBERT J. BAKER, M.D.
Associate Director, Department of Surgical Education, Cook County Hospital

Discussants:
GERALD O. McDONALD, M.D.
Associate Professor of Surgery, University of Illinois College of Medicine

ROBERT L. SCHMITZ, M.D.
Associate Clinical Professor of Surgery, Stritch School of Medicine of Loyola University; Attending Staff, Cook County Hospital

IRVIN F. HUMMON, M.D.
Director, Department of Radiology, Cook County Hospital; Clinical Professor of Radiology, Stritch School of Medicine of Loyola University

Dr. Robert J. Baker: A conference dealing with palliation for cancer must of necessity deal not only with the science but also the philosophy of medicine. Most decisions made in the management of patients with incurable cancer are based primarily on characteristics of the specific neoplasm; but also to be considered are the personality of the patient, his financial and family situation, the previous experiences of the responsible physician, and a half dozen other tangible and intangible factors.

Over-all, our aim in palliation is to prolong life, but not to prolong suffering. Treatment, regardless of its nature, should not leave the patient with a greater handicap or more miserable than not treating the original disease.

Deciding what therapeutic measures to use in such difficult situations must rest with physicians of experience, knowledge, and conscience.

The discussants today are men of wide experience in this field, and their contributions are well known. In contradistinction to our usual format, I would like to ask Dr. Robert Schmitz of our attending surgical staff for some introductory remarks about palliation in these patients.

Dr. Robert L. Schmitz: As Dr. Baker has mentioned, in the palliation of cancer a physician's philosophy may be as important as his skill. Some men are reluctant to do more than give narcotics for relief of pain. Others will do extensive surgical procedures where palliative gains will be minimal at best. Some

surgeons are reluctant to do even curative operations that will leave the patient considerably handicapped or deformed. Just what your approach is will be colored by your personality as well as your experience.

It is my feeling that in any such decision the patient should be given as much insight into the problem as possible so that he can have a voice in the matter. Most persons have very vital reasons for wanting to live, and it is amazing and inspiring to see the courage they will have, even about a palliative procedure, if they are given a vote. In the case of children, the parents will grasp at any straw to extend the patient's life even a little bit. To us the recent extension of life in the leukemias of childhood is a relatively insignificant thing. We have extended life two or three or even five years on occasion, and to us this is very little because we have not cured the patient. But to the parents it is of great importance.

The first objective of palliation is to relieve pain; the next is to extend life. There is a long list of lesser objectives, such as prevention of ulceration, relief of bowel obstruction, arrest of bleeding, interruption of convulsions, and drying of exudates. The object never is to prolong suffering; although we are accused of this on many occasions, no one has this intent. It is not always possible to tell what extension of life will bring to the patient. Sometimes it is not wise to interfere in the course of incurable cancer if the potential gains are small and the palliative measure is great. A painful death may be substituted for a painless one. Examples of inappropriate palliative procedures would be an elaborate local operation in a patient with generalized metastatic disease, or, specifically, a urinary diversion operation in a patient with Stage IV cervical carcinoma who is in progressive uremia. Uremia is a relatively painless type of death, and you will not extend life much by diverting the urinary stream; moreover, you may save the patient for a very painful death with perineal fistula and sacral plexus invasion.

So you must weigh what you expect to gain against what you choose to do. The approach should be optimistic. No case is entirely hopeless as far as the patient is concerned. There is usually something to be done; and when nothing else is applicable, there is occasionally the possibility of spontaneous regression. If you can comfortably prolong a patient's life, who knows which tomorrow will bring a breakthrough in the treatment and cure of cancer?

DR. BAKER: The universal problem is what to tell the patient and what to tell the family when you have operated and the situation is hopeless, or you have left tumor behind because of distant metastasis. Do you have any guiding principles in these situations?

DR. SCHMITZ: There are no absolute rules because exceptions are always in order. In general, the relatives should be given the information as frankly and fully as possible. It is important that they understand the prognosis so that the physicians will not be blamed when the patient's course is downhill in spite of all efforts. When asked how long the patient will live, I have no objection to making a guess as long as the relatives understand it is a guess and that it may be very wrong.

Usually I am frank with the patient also. I do not force information on him, but I answer his questions honestly in terms I hope will not frighten him too much. Occasionally I may be evasive or say nothing if the patient does not ask. However, it is important not to lie to him because eventually he will discover that you have. Then he is suddenly in a frightening, lonesome situation in which he can no longer trust even his doctor or relatives.

The informed patient usually makes a good adjustment quickly and cooperates well instead of fretting and shifting physicians if he fails to improve.

Relatives will often ask that you not inform the patient or that you lie to him. I do my best to change their minds, or, if I cannot, I usually refuse to lie, but I will be evasive. It is sad to see the tragedy that can result when a patient dies with his affairs in disarray because he didn't know he had a fatal illness.

DR. BAKER: If you have a patient who is very emotional or seems unstable, such as a mother of two children who insists that she has to know, do you tell her the unvarnished truth or do you attempt to evade the question?

DR. SCHMITZ: If she asks I will tell her,

unless there is some psychiatric reason for not doing so. It is amazing how well people adjust to this information after the initial depression. There is, of course, a tremendous letdown for a day or two, but then they come around and are easy to manage. These patients usually do not ask why they are not getting better because they know you are doing your best.

Dr. Baker: With these excellent introductory remarks, we shall present the first case.

Case 1

L. S., a 7 year old Negro female, was admitted to the Children's Hospital of the Cook County Hospital with a history of increasing abdominal distention and inability to take solid foods, both over approximately one week.

Physical examination revealed a diffusely and symmetrically enlarged, tense, tender abdomen with a smooth, rounded mass occupying the right upper abdomen and extending to the right iliac crest. It was an extremely firm mass and could not be differentiated from the liver and spleen. There was generalized lymphadenopathy.

Roentgenogram of the chest showed a nodular infiltrate throughout both lung fields. Other work-up revealed a moderate anemia. The patient was explored, and biopsy of the large liver studded with nodules was reported as "hepatocellular carcinoma."

Dr. Schmitz, how would you treat such a child with an inoperable tumor of this type?

Dr. Schmitz: There is little to be offered surgically. In a case of hepatoblastoma that is localized or where nodules are localized to one lobe of the liver, it is possible to do a hepatic lobectomy. In this situation, other than biopsy, I do not think anything further could have been accomplished. I will say nothing about perfusion which might be of some value but difficult to carry out technically.

Dr. Baker: Dr. Hummon, will you discuss some of the broader principles involved in the radiotherapy of tumors?

Dr. Irvin F. Hummon: In this particular case we would not have a great deal to offer, any more than the surgeon has. Our philosophy in treating these advanced cases, however, is never to give up hope. Our experience has been that even in a very hopeless case you will sometimes get a response advantageous to the patient. If you approach these problems with pessimism, it is transmitted to the patient; you should always have the optimistic outlook that this might be the one case that could have a good result.

What do we radiotherapists have to offer from a palliative standpoint? If the disease is very widespread, it is physiologically impossible to radiate the whole patient because the amount of radiation a patient can take is limited to about 1,000 roentgens; that is not adequate to cause any amount of regression of a tumor, unless it is an extremely sensitive type, such as lymphoma or leukemia. So when you have whole body involvement, you cannot do much. If, however, you have a localized area that is troublesome because of bleeding or because of its bulk or something of that nature, then we can treat such a lesion with external radiation. Frequently we may be able to obtain regression in size or cessation of bleeding that will be advantageous to the patient.

In a few instances the use of radioisotopes for palliation is very good. For example, serous fluid in the chest secondary to metastatic disease can frequently be controlled successfully with radioactive gold, or chromic radiophosphate, in the serous cavity. As a palliative measure it is simple and effective in many cases. A second form of palliation with isotopes is the use of radiophosphorus in treating bone metastasis from carcinoma of the breast. This frequently gives a very satisfactory regression of the bone lesions with evidence of recalcification and marked relief of pain for as long as two or three years. Eventually the patient will die of the disease, but the treatment has prolonged useful life over a period of considerable value to the patient, particularly if it is a young woman with a family to whom a year or two means a good deal.

There are two radiological approaches to this particular patient with a liver lesion. The first is by external radiation. Because of the size and location of the lesion and the desirability of giving a high tumor dosage, perhaps it would

have reduced the size of the lesion. It would not, however, have changed the course of the disease in any way at all. The second approach is with intravenous isotopes. We treated one patient with metastatic disease of the liver with intravenous radioactive gold about five years ago; this one patient has survived, but we have tried the same technic with others and have not been so successful. Unless you have some specific case such as I have outlined with carcinoma of the breast with bone metastasis, the radiologist is limited to palliation which would result in diminution in the size of the tumor, control of bleeding, getting rid of infectious masses that will slough, or something of that nature.

Dr. Baker: Can you clarify something for us? Is there a basic difference from the standpoint of effect on a tumor and on the patient between standard x-ray therapy and supervoltage therapy, and do you always use cobalt and cesium in supervoltage therapy?

Dr. Hummon: Dose for dose, the results you get with ordinary x-ray therapy can be considered no different from the other. The great advantage of supervoltage therapy lies in the ease with which we can administer a therapeutic dose to a patient. Also, there are lesser side effects, such as skin reaction and general malaise, that may accompany any radiation therapy. We will choose the form of therapy — superficial, deep, or supervoltage — according to the size of the patient and the location and size of the tumor. Both cobalt and cesium are forms of supervoltage therapy. Cesium can be used best for head and neck lesions, whereas cobalt is used mainly for deeper lesions in the abdomen and in the chest.

Dr. Baker: Dr. McDonald, we have presented the most difficult of our patients first with the knowledge that we were going to come to your particular interest, chemotherapy. Will you tell us what you would do for such a patient?

Dr. Gerald McDonald: I am more pessimistic about chemotherapy than Dr. Schmitz. Unfortunately, I know of no single case in which carcinoma has been cured by chemotherapy. This excludes chorioepithelioma, a peculiar and rare tumor that has been reported cured by chemotherapy alone. At the present time, chemotherapy is palliative and should be employed only after consideration of several factors. Chemotherapeutic agents have been designed to prevent multiplication of tumor cells. The tumor cell is so similar to the normal body cell that whatever affects it unfortunately affects the normal cell as well.

When a chemotherapeutic agent is administered intravenously, certain organs and tissues act as barriers. For instance, nitrogen mustard is fixed by the tissues. Therefore, before it reaches the cancer cells, some of the drug has been inactivated by tissue cells. By the time the drug reaches the cancer, there may not be a sufficiently strong concentration to affect tumor cells. If there is sufficient concentration of the agent, other body cells also are affected. Then the patient becomes nauseated, vomits, and develops hematopoietic depression.

If we give a dose that is sufficient to kill cancer cells, it may also kill the patient; so we have a marked limiting factor in the use of chemotherapeutic drugs. The search is on for drugs that will be tumor-specific, but now we do not possess a completely specific agent.

But let us discuss this case of hepatocellular carcinoma. The treatment with chemotherapy in this disease has been very poor. There was a recent report of 10 cases treated with 5-fluorouracil by an investigator at Wisconsin, and interestingly, in these cases, one-half did obtain objective regression. What does that mean? It means decrease in the size of the lesion and improvement of the patient's condition, but only for short periods of time. Therefore, much care and much thought and consideration should go into any decision to give chemotherapy because it will probably affect normal cells and hence will make the patient ill.

Today we are swinging to the concept that to get an objective response in tumor therapy with chemotherapeutic agents, we must treat the patients differently. Some years ago there was a swing the other way; it was felt that these drugs were specific, and the physicians would say, "We can give smaller doses and patients will not have side effects, and we will get tumor response." This has not worked well,

TABLE 1.—COMMON ANTITUMOR DRUGS

Type	*Tumor Sites Affected*	*Side Effects*	*Specific Agents*	*Action*
A. Alkylating agents	Breast Ovary Melanoma Lung	Depress hematopoiesis GI mucosa slough	Nitrogen mustard PAM Thio-TEPA	Radiomimetic—cytotoxic, mutagenic, most active against cells in mitosis
B. Antimetabolites	Breast Choriocarcinoma (Methotrexate) Colon (5-FU) Pancreas	Leukopenia Thrombocytopenia GI slough	Antipurines (6—mercaptopurine) Antipyrimidines (5-FU) Folic acid antagonists (Methotrexate)	Compete with normal metabolites by counterfeiting them
C. Antibiotics	Testicular embryoma Wilms tumor Neuroblastoma Sarcomas	Alopecia Depress hematopoiesis	Actinomycin D Mitomycin Streptovitacin	Investigation purely empirical—mode of action probably varies with each compound

and at the present time every patient who gets a good response has had to receive very heavy doses. Obviously, he has considerable side effects. This is true in perfusion, as well. The results with perfusion of isolated body segments have been very disappointing except in melanoma, and actually melanoma of the extremities. This is wonderful because it may prove to be a helpful adjunct in the over-all treatment of malignant melanoma. However, with other malignant disease, perfusion has not proved to be the answer. In some cases of pelvic carcinoma with a fixed pelvis and much pain, perfusion has decreased the pain and provided some relief, albeit transitory. Total body perfusion and segmental intra-arterial administration of agents appear to offer some hope (Table 1).

I am in perfect agreement with Dr. Schmitz on what we tell the patient. As soon as you become evasive, you find yourself avoiding the patient on rounds or making very brief bedside visits. This is bad. The sooner you put it frankly the better. In treating any disease you know your patient and spend some time with him. When you do this and discuss the situation with him, you will not have that reticence about going in to see the patient with advanced malignancy. If you continue to evade the answer about what he has and what is his prognosis, then you will not go into the room to see him. You will leave that patient out on a lonely island, and that is wrong.

I don't think you should use chemotherapy unless you feel there is hope that your patient will respond and receive benefit from it. I think you should discuss it with the patient and tell him that this is not a tried-and-true procedure as is an appendectomy for appendicitis. However, you are willing to try it if he understands the situation and the probable side effects. If this is not discussed beforehand with the patient, the mention of an anticancer drug to the patient means a certain cure. If no results are forthcoming after treatment, and he manifests marked toxicity to the drug, he will be most distraught.

Carcinoma of the breast and prostate are hormone-dependent lesions that are approached in a different manner. Chemotherapy in these instances should be reserved until after the proven effects of castration and hormone therapy no longer contain the tumor. In the treatment of advanced breast cancer, castration, hormone therapy, and adrenalectomy many times provide exceptionally satisfactory, and on some occasions, prolonged palliation. When this regime fails, then chemothrapy should be employed. This is a last-ditch effort because, if I leave you with nothing else, I must emphasize that chemotherapy is still experimental. Until we discover more specific drugs, it must con-

tinue to be experimental therapy.

Dr. Baker: Do you think that the general surgeon who operates upon patients with carcinoma of the colon and who determines that the tumor is not curable should use nitrogen mustard, either intraperitoneally or intravenously?

Dr. McDonald: Certainly not, because gastrointestinal lesions are resistant to nitrogen mustard. Better palliative results have been achieved with radiation than with chemotherapy, although these are far from satisfactory. The new drug, 5-FDUR, appears to offer some benefit in the palliation of cancer of the colon.

Dr. Baker: How would you treat this child?

Dr. McDonald: I would use 5-fluorouracil with great reluctance, because it would only make the child sicker.

Dr. Baker: When you use these agents, do you give a single large, or repeated smaller, doses?

Dr. McDonald: Our results are much better with large, massive, toxic doses given as rapidly as possible over a period of 7 to 20 days. Let the patient return to normal and then treat him again. At a recent meeting on cancer several groups discussed the continuous administration of drugs by intravenous drip, giving smaller amounts over a long period of time. Their results were much better with continuous drip given over a period of 24 hours than with single daily injections.

Dr. Joseph Greengard, director of pediatric education: In children with embryonal tumors that are radiosensitive, some people believe that these drugs potentiate the x-ray and that simultaneous use of the drug will reduce the necessity for maximum doses of x-ray. How do you feel about that?

Dr. McDonald: All I can say is that their results look interesting. The number of cases so treated was small. This may hold promise, but the results must be shown to be equal to those of radiation alone after the patients are followed for a longer period of time.

Dr. Baker: This child, because of the diffuse metastases in both lung fields, the liver, and spleen, was treated with actinomycin D. She survived for a little over a month, so the results were as Dr. McDonald indicated. The side effects in her case were extreme.

Case 2

L. D., a 3 year old Negro male, was admitted with a history of hematuria and a mass of unknown duration in the left flank. Nephrectomy was performed and a Wilms tumor removed. X-ray therapy was begun and four months later the child was readmitted with paraplegia at the level of T-12 to L-1. Spinal fluid was xanthochromic and protein over 1000 mg. per 100 ml.

What would be your therapeutic approach in this case?

Dr. Schmitz: I would like to use preoperative radiation before attacking the Wilms tumor. The idea is not to shrink it down but rather to use an additional curative agent. I would emphasize that the surgical approach should be through an anterior incision with control of the renal pedicle before any other manipulation, thereby cutting down the possibility of dispersion of tumor cells. In this case, the problem now is a neurosurgical one, and I would surgically decompress this spinal cord. For palliation, my inclination would be to give actinomycin D and radiation.

Dr. Baker: What would you do, Dr. Hummon?

Dr. Hummon: I would agree with Dr. Schmitz on preoperative radiation. There was some interesting work done years ago at the University of Illinois, showing that preoperative radiation, or rather radiation with a two- to four-week waiting period before surgery, has a much greater probability of complete eradication than radiation followed by prompt removal of a tumor. There is some host response to an irradiated tumor that we still do not understand too well, but our general results have always indicated that if the tumor is left in place, irradiated, and then removed, recurrence and metastasis are less frequent. I have one case of a Wilms tumor treated only with radiation, and the patient, now 19 years old, has no evidence of recurrence. From the standpoint of the spinal lesion, I would suggest that

radiation be given over all of the spine because, if this is a metastatic lesion of a Wilms tumor, it should respond very well.

Dr. McDonald: I think preoperative radiation should be used. I would like to ask how long you would give preoperative radiation before surgery?

Dr. Schmitz: The usual wait is six weeks, but I prefer four weeks.

Dr. McDonald: Some of the Eastern group have offered a controversial opinion about this. They say that if too much radiation is given before surgery, there may be tumor necrosis and more dissemination by spillage than if preoperative radiation is not used. I do not know, but there are good figures to support this. There was a group at Children's Hospital in Boston years ago who had an x-ray machine right in the operating room, and with the abdomen open gave the first dose of x-ray. This is now unnecessary because of better techniques.

As for preoperative radiation in other tumors, Henschke from Memorial in New York reported at the American Cancer Society meeting three years ago that 10-year survival figures of patients with rectal carcinoma treated preoperatively with radiation were markedly superior to those of patients treated with surgery alone. I have not heard anything about this recently.

Dr. Baker: Would you have used actinomycin D at any time in the course of this case?

Dr. McDonald: No; I would use radiation alone.

Dr. Baker: In this instance, both actinomycin D and radiation were employed. His paraplegia responded very well, but he did exfoliate hair and nails. He had two further courses of actinomycin D. Would you give this at intervals at predetermined times or do you wait for masses or other signs of metastasis?

Dr. McDonald: In general, I believe repeated courses should be given until presumptive evidence indicates the tumor is controlled. However, others prefer to administer smaller doses, weekly or byweekly.

Dr. Baker: Have you had experience with the use of autologous marrow after chemotherapy?

Dr. McDonald: I have not, but people in my department have. They have had good luck in a few patients by removing marrow, giving total body chemotherapy, and replacing the marrow. This has seemed to protect the patient, although it is not without danger.

Case 3

F. S., a 2 year old Negro male, was admitted with a firm, irregular 4 x 4 cm. mass over the left cheek, a 2 x 2 cm. mass in the upper lip, and a small mass lateral to the left eye which seemed to be fixed to bone. Examination of the abdomen revealed a large, hard, bosselated mass extending from the left flank across the midline to the right side. Biopsy of the facial mass yielded metastatic neuroblastoma. Subsequently, resection of most of the abdominal mass was undertaken.

Dr. Baker: What would be your approach in this case?

Dr. Schmitz: I would make every effort to take a neuroblastoma out totally, if possible. I treat this disease very energetically. Even with diffuse metastases 25 per cent can have a long term spontaneous arrest. There is a tendency for these cells to mature by themselves in some way; so if you do nothing but keep the child alive, the disease may burn out. I would eradicate the primary lesion surgically and go after the metastases with irradiation.

Dr. Baker: Dr. Hummon, how do you feel about radiating a lesion in the area of the outer canthus of the eye?

Dr. Hummon: It would depend on the location, but we can protect the eye very well.

Dr. Greengard: Do you have any experience with massive doses of vitamin B-12 therapy?

Dr. McDonald: I know only what I read about. But the British investigators are very optimistic and interested. There is a tremendous tendency for these tumors to mature, so whether this is what happens or whether vitamin B-12 helps I do not know.

Case 4

K. S., a 3 year old white female, was admitted with a history of fever, abdominal pain, and dyspnea of three days' duration. Admission temperature was 103 F. rectally, and dullness



FIGURE 1. Admission chest x-ray, showing massive left exudative pleuritis with marked shift of the mediastinum to the right.



FIGURE 2. Follow-up x-ray 11 months later showing bilateral pulmonary metastases, involving the right mid-lung field and the lower half of the left hemithorax.

and decreased breath sounds were noted over the left lung field. X-ray of the chest revealed mediastinal shift to the right with opacification of the left lung field (Fig. 1).

Hepatosplenomegaly developed in the hospital. At thoracotomy, a huge tumor, apparently arising from the left hemidiaphragm and filling the left chest, was removed. The tumor was reported to be an intrathoracic teratoma. Repeat chest x-ray 11 months later showed bilateral pulmonary metastases (Fig. 2).

DR. BAKER: When the tumor was removed, it proved to be 15 cm. in diameter. About 10 months after surgery the lung fields were filled with tumor again, and the patient had recurrence of cough and some shortness of breath.

DR. HUMMON: When you are faced with bilateral pulmonary metastases, the end certainly is not difficult to see; but occasionally we can get some response in a case like this.

DR. BAKER: Would you use actinomycin D?

DR. MCDONALD: I would not know in this case.

DR. BAKER: The patient had been treated with actinomycin D and had some subjective benefit, but after these last films were obtained we knew there was no lasting effect.

I want to thank the discussants. You have all been most helpful in discussing these difficult, if not impossible, problems, and I think the attitudes toward the incurable cancer patient expressed here are especially valuable for the younger men to bear in mind at all times.

Summary and Conclusions

1. Palliative treatment denotes therapy directed toward alleviation of specific symptoms caused by uncontrollable disease or anticipated in its further course. It is an effort to prolong the *comfortable* period of the remaining life span.
2. Palliation of solid tumors falls into several spheres:
   a. Ablative surgery
   b. Radiotherapy
   c. Chemotherapy (local, systemic)
   d. Regional infusion
   e. Regional perfusion

(continued on page 289)

The View Box

Franz Gampl, M.D., *Chicago*

The patient, a 59 year old foundry molder, sought medical advice because of general weakness, severe shortness of breath, and a productive cough. He had "asthma" and frequent "colds." The symptoms, of 5 years duration, became more severe in the past 6 months. His appetite was poor, and he had lost 8 pounds in the last two months. He denied hemoptysis or exposure to tuberculosis.

He was moderately emaciated. The pulse was 92 and irregular. Blood pressure and temperature were normal. The mucous membranes and fingernails were cyanotic. Breathing was labored with supraclavicular and intercostal retractions. The upper thorax was dull to percussion, and the lower lung fields hyperresonant. Moist rales, rhonchi, and wheezes were heard over both lungs. The heart was not enlarged. The pulmonic component of the second heart sound was accentuated.

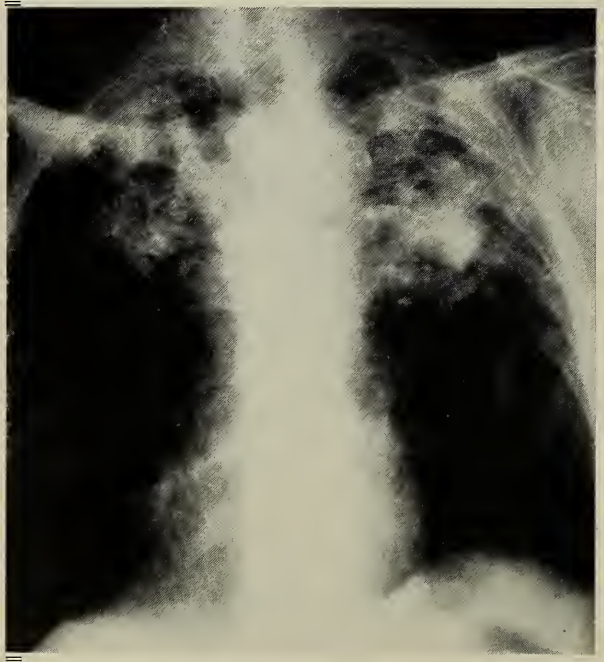


FIGURE 1. Chest radiograph on admission

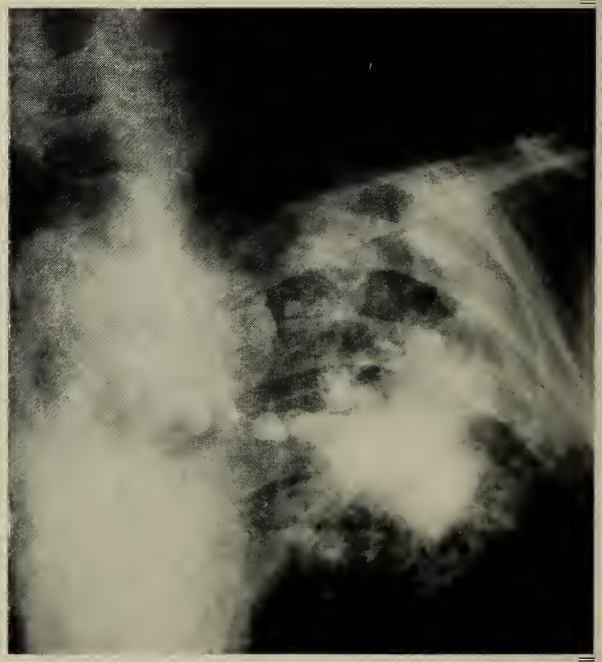


FIGURE 2. Enlargement of the left upper lung field

What is your diagnosis?

(1) Pulmonary tuberculosis
(2) Bronchogenic carcinoma
(3) Complicated silicosis
(4) Sarcoidosis

(continued on page 289)

From the radiology department, Cook County Hospital



MEDICINE in the OUT-OF-DOORS

A Pocket First-Aid Kit

Julius M. Kowalski, M.D., *Princeton*

The Outdoor-Minded patient on occasion queries his family physician about a first-aid kit. Many types and sizes are available from drugstores and surgical supply outlets. More elaborate and specialized kits or cabinets developed over the years are used in industry, mining, oil drilling, lumbering, public utilities, and the military. No one kit is adequate for all possibilities likely to arise in the field; at best, it is a compromise. The experience of the first aider and his ability to improvise on the spot is often more important to the injured than the kit.

For the average outdoorsman on a day's outing of no more than several hours' drive from habitation or a telephone, a pocket kit is sufficient for most purposes. What the hunter or fisherman carries with him in addition to the kit, and how he uses it, is important. Among these accessory items is the pocketknife for cutting and shaping splints from bows, stripping clothing, removing slivers, cutting tape and bandages. A good quality pocketknife with sharp blades should always remain in the outing trousers. When the need for it is urgent, discovering it was left at home in another suit is most frustrating. Regrettably, the handling of a pocketknife is becoming a lost art. Few boys know how to make a whistle from a green willow stick.

Large bandana handerchiefs — the familiar red or blue variety — should be tucked into a pocket. On hot, humid days they can be used as a sweatband to keep the flood of perspiration from the eyes and also as effective shields for head and neck against sun, wind, dust or incessant insect attacks. On cold days, when wrapped around the neck, they retard the upward dissipation of body heat.

Two tied kerchiefs make an effective sling for wrist or arm. (More complete kits have a 40-inch triangular bandage.) They can be used to secure dressings to an extremity or for the rare emergency when a tourniquet is indicated.

A length of sash cord at least 4½ feet long should be in a jacket pocket. It can be used for the ankle hitch to immobilize the sprained ankle. This cord, with the bandanas and splints, will effectively immobilize a fractured extremity.

Paper tissue, facial or other variety, is usually in the coat or jacket that one uses for outdoor activities. In the event of moderate bleeding from a laceration, the tissue can be placed over sterile dressings and sustained pressure applied to the wound.

As for the pocket kit itself, many items contained in it are already in the average home medicine chest or available in drugstores:

Six band-aid plastic strips, individually wrapped, for small lacerations, abrasions or blisters.

Eight butterfly closures — four medium size and four large size — to bridge larger lacerations. In many instances, a laceration can be closed as effectively with these as with sutures.

One roll of one-half-inch wide plastic ad-

hesive tape to secure dressings or hold wound edges together. It sticks much better to moist skin than the old-fashioned tape.

Six sterile gauze pads, four inches square, 12 ply, individually wrapped, to cover any breaks in the skin; when folded they can be used as eye patches.

One roll of two-inch conforming gauze, five yards long. It will not slip or slide as the old roller gauze did, will stretch in length and breathe, and conforms to fingers, toes, and other body areas.

One roll of four-inch wide, five and a half yards long, elastic bandage. This is a versatile item for securing dressings to the larger body areas. It is used to immobilize a sprained or fractured ankle, wrist, knee, or ribs. It is ideal for that grave but fortunately rare injury, the sucking chest wound, which must always be closed quickly and as completely as possible.

Two large, white, well laundered handkerchiefs, to be used as covers over sterile dressings, or their firm edges can be used for removing particles from the eye.

One small bar of white soap for cleansing wounds with water. This generally is better than dousing a dirty wound with a bacteriostatic solution.

Eight safety pins, four large and four medium.

All of these items can be packaged into a plastic frozen food bag and secured with four rubber bands so that the entire kit measures approximately 5½ x 4½ x 2½ inches. It fits into a hunting shirt or jacket pocket. Properly packed and tightly bound, this kit will withstand rain or perspiration.

In areas where the poisonous snakes are likely, the compact plastic snake kit should be carried at all times.

The use of the materials in this kit is for field first aid only, and medical aid is to be sought as soon after injury as conditions permit. With such a kit one can cope with the usual injuries encountered while hunting, fishing, camping, or just plain bird watching.

If this kit is too bothersome, then at least throw several band-aids into a pocket on the next outing.

Correction — The physiologic blink usually consumes 16/100 to 20/100 of a second instead of 1/16 of a second as appeared in the article in the October Journal, page 239.

What About Relative Value?

Because there is still considerable doubt about what a relative value scale is and what it is used for, the Relative Value Committee is planning a question-and-answer forum in a future issue of the Illinois Medical Journal.

If you have a question about relative value, please send it to Dr. C. Elliot Bell, Chairman, Relative Value Committee, 360 N. Michigan Ave., Chicago 1, Illinois. Every question will be answered and a representative group of questions and answers will appear in the Journal.

The View Box—diagnosis and discussion *(continued from page 286)*

The diagnosis is complicated silicosis.

Although there is no single radiographic finding that permits the diagnosis of silicosis, the following changes present on the chest radiograph (Figs. 1, 2) establish the nature of the process with a high degree of accuracy:

(a) The silicoma is a conglomerate mass of coalescent nodular densities with fibrotic strands radiating from its periphery (left upper lobe).

(b) Calcifications of the eggshell type found in the hilar nodes and in the mid-lung fields are signs of superimposed tuberculosis or fungal infection not uncommon in silicotic lungs.

(c) Fibrosis of both upper lobes with elevation of the hilar shadows produce the appearance of "angel-wings."

(d) Cavitation is secondary to ischemic infarcts, or due to superimposed tuberculosis or fungal infection. (Sputa were negative for tuberculosis; Mantoux skin test was positive).

(e) Bullae or cyst formation due to bronchial scarring with localized obstructive emphysema.

(f) "Waterfall" or "rainstorm" appearance of the middle and lower lung fields, which is due to the elongated pulmonary vascular shadows descending from the elevated hili to the dome of the diaphragms.

(g) Generalized pulmonary emphysema with increased radiability of the lower lung fields, and flattened diaphragms.

The evaluation of workers exposed to dusts containing silicon dioxide is a difficult diagnostic challenge. Small, fibrous-hyaline, miliary type of nodules appear commonly in the early stage of the disease. These by themselves are not characteristic. The concentration of the dust at the place of employment, the size of the dust particles, and the duration of exposure are factors of importance. The clinical appraisal of the patient, including respiratory function studies and extensive radiographic workup with serial radiographs over regular time intervals, will give further clues as to the nature and degree of the disability of the worker.

The typical findings in the late stages of silicosis are rarely a diagnostic problem.

Further Reading

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2. Pendergrass, E. P.: Silicosis and Other Pneumoconioses. Am. J. Roentgenol., Radium Therapy and Nuclear Med. 80:1-41 (July) 1958.

Conferences *(concluded from page 285)*

Combinations of these modalities are frequently necessary.

3. Extirpation of a primary malignant lesion, even in the presence of metastases, may prevent further tumor seeding, delay growth of metastases, and eliminate discomfort of late complications.
4. When there is no hope of definite cure, the magnitude of surgical procedures should not be extended beyond that which may be necessary to provide maximal symptomatic relief.
5. Combined therapy, i.e., radiation and chemotherapy, or surgery and chemotherapy, or all three, is being extensively studied. Two presumptions stimulate these studies:
   a. Tumor cells introduced into the blood stream by operative manipulation of the tumor may be prevented from implanting as metastases with one or the other of these adjuncts.
   b. Small tumor deposits, undetected at surgery, may be more susceptible to these measures than the larger masses representing the primary lesion or overt recurrences.
6. Perfusion or infusion, usually with one of the alkylating agents, may be of benefit in those circumstances where the tumor is localized to one site or area. Unfortunately, systemic metastases with most tumors is the rule.

Hyperinsulinism Due to Hyperplasia of the Islets of Langerhans

Gilbert D. Fish, Jr., M.D.,*
William H. Isham, M.D.,*
Francis C. Tucker, M.D.,** *Freeport*

In 1951 Friedlander[1] reviewed the world literature and found 22 cases of histologically proved hyperplasia of the islets of Langerhans, all from foreign publications. The present case is reported to add to the literature because of the relative rarity of the condition, its lack of recognition in this country, and also to suggest the possible association of stenosis of the sphincter of Oddi with islet cell hyperplasia.

Case Report

A 44 year old white woman gave a vague history of symptoms extending over a period of about five years. About four years previously she had been evaluated at another institution for episodes of perspiration, jittery feelings, and sensations of hunger. A glucose tolerance test at that institution was suggestive of hyperinsulinism but was believed to be outside the range consistent with the diagnosis of an islet cell tumor of the pancreas. The diagnosis was hyperventilation syndrome associated with anxiety episodes.

The patient's symptoms remained relatively unchanged until her first admission to the hospital brought about by sudden collapse and uncontrollable crying. She was initially treated by parenteral sedation without any effect whatsoever. As soon as an adequate history was obtained, intravenous glucose gave prompt relief of all symptoms. Further inquiry revealed that the patient required between-meal feedings to avoid attacks of faintness.

Work-up, both as a hospital patient and then as an outpatient, revealed the following: Gall bladder x-rays were normal. A gastrointestinal series was interpreted as consistent with a duodenal ulcer, although no niche could be demonstrated. Gastric analysis showed no free hydrochloric acid and a fairly low total acidity. The glucose tolerance tests (both pre- and postoperative) are shown in table 1, page 292.

She failed to respond to dietary management as might be expected in a functional type of hypoglycemia. Her symptoms were not suggestive of duodenal ulcer, explaining perhaps why she did not respond to an ulcer regimen. She developed a diarrhea which persisted for six weeks until the time of surgery. The patient was advised to fast, and she fainted at the end of 11 hours. Recovery occurred immediately with the administration of glucose. An exploration was advised because she fulfilled Whipple's triad in the diagnosis of an islet cell tumor.

At surgery the pancreas was thoroughly mobilized and examined in its entirety. The tail of the pancreas differed in appearance and

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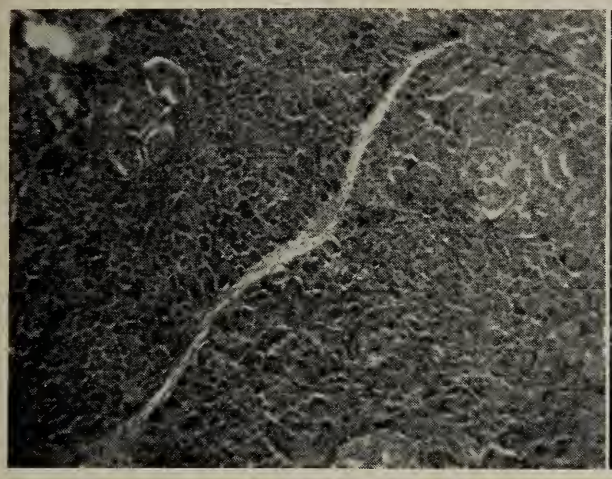


FIGURE 1. Normal pancreas.

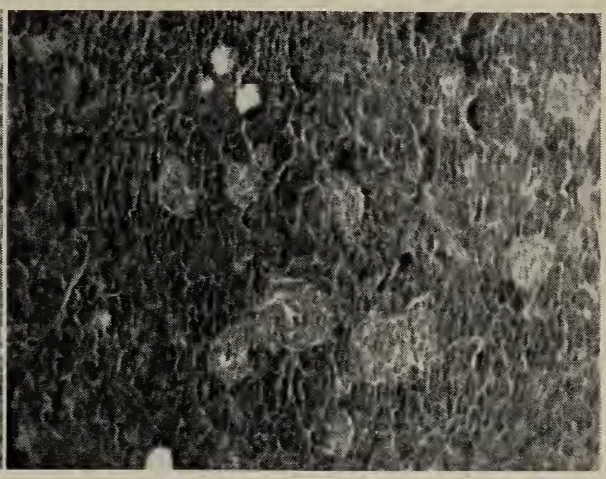


FIGURE 2. Islet cell hyperplasia. Note increase in number of islets as well as in islet cells.

was firmer and more lobular than the rest of the gland. The greater curvature of the stomach and hilum of the spleen were carefully examined for evidence of aberrant pancreatic tissue, but none was found. No duodenal ulcer could be demonstrated. The duodenum was opened and the ampulla of Vater examined. A stenotic sphincter of Oddi measuring 2 mm. in diameter was found, and a sphincterotomy was done. The abnormal-appearing tail of the pancreas was resected. The pathologic report was as follows: Pancreatic tissues with increase in numbers and size of the islets of Langerhans (Figs. 1 and 2).

The patient had a normal convalescence and has since been free of symptoms to the date of this writing. A glucose tolerance test four months postoperatively showed a return to almost normal blood sugar (Table 1, page 292).

Discussion

Although tumors of various types, including retroperitoneal tumors and metastatic lesions in the liver, have been cited as the cause of isolated cases of hyperinsulinism, this paper deals only with hyperplasia of the islet cells per se as a possible cause of this condition.

Writers in this country seem unwilling to recognize the possibility of hyperplasia of the islet cells as the cause of hyperinsulinism. ReMine[2] states that he knows of no authenticated case in which hyperfunction of the islet cells has occurred in the absence of a tumor. Menguy[3] states that there is no evidence that such an entity exists. The consensus seems to be that if a tumor is not found, the surgical exploration is inadequate. To carry this type of reasoning further, one would necessarily have to assume that a patient who has a good clinical result from a partial pancreatectomy, in the absence of a demonstrable tumor, must have been diagnosed incorrectly, and that the hyperinsulinism was functional in nature. Although such may well be the case in some instances, it would seem that such an assumption would be hard to justify in the presence of histologic evidence of hyperplasia in the resected specimen.

It is granted that a very small functioning islet cell tumor could have been missed in any exploration short of a total pancreatectomy. Nevertheless, the exploration in this case was felt to have been very thorough. Most functioning adenomas are greater than one-half centimeter in diameter. The pathologic diagnosis seemed to confirm this reasoning.

Hyperplasia is a recognized pathologic entity in other tissues of the body. The hyperplasia of the thyroid and parathyroid glands are examples. It would seem that an islet cell adenoma, micro-adenomata, and hyperplasia may be more a matter of degree of the same pathologic process, or possibly even reflect the semantics of the interpreter. Would not a 1 mm. adenoma be simply a localized area of hyperplasia? It would seem that an entire tail of the pancreas composed of hyperplastic and

hypertrophied islet cell tissues might create more insulin than a minute adenoma.

The histologic appearance of hyperplasia does not seem to be an absolute one. In general, there is both hyperplasia and hypertrophy of the islets. Gomori's stain reveals a relative increase in the beta cells and a paucity of alpha cells. In some instances the beta cells contain giant nuclei. In the so-called micro-adenomata there is an increase in the number of "pure" beta cell islets (or adenomas) and an increase in the alpha cells in the otherwise normal islets.[4]

In the case reported here, multiple sections of the tail of the pancreas were compared with comparable sections of apparently normal pancreas. There is little doubt in our minds that there is hypertrophy and hyperplasia of the islet cells, and a definite increase in the beta cells as demonstrated by a Gomori stain.

In his review of the literature, Friedlander[1] pointed out the conditions under which hyperplasia of the islets of Langerhans have been found.

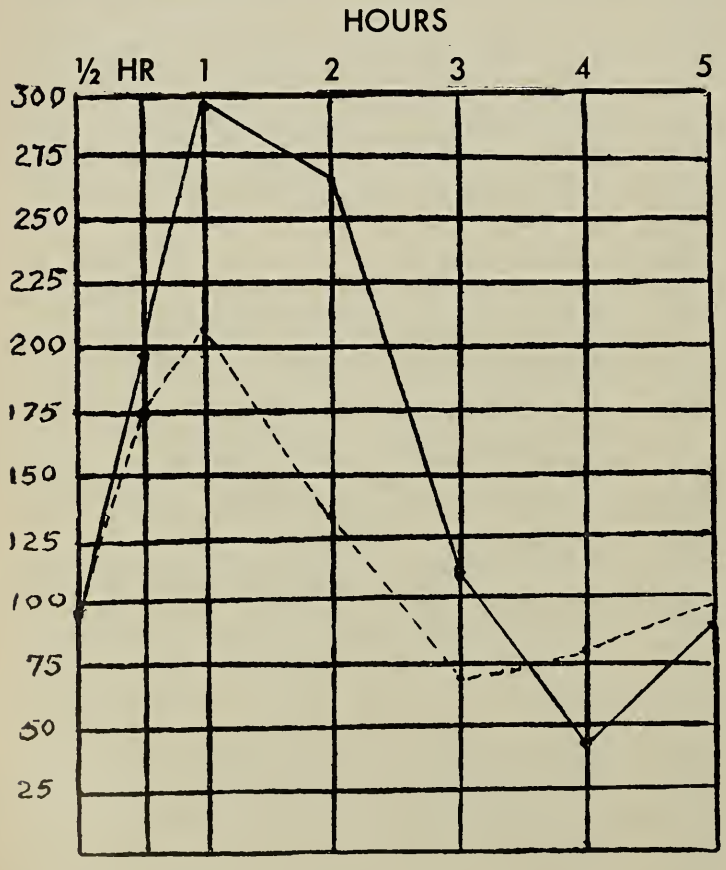
1. Chronic or traumatic pancreatitis.
2. Obstruction of the pancreatic duct by stones, tumor, or atresia resulting in cirrhosis and atrophy of the pancreas.
3. Lesions in organs adjacent to the pancreas (i.e., ulcer on the posterior wall of the stomach).

These clinical findings correspond well to animal experiments that demonstrate hyperplasia of the islets following ligation of the pancreatic duct, with resultant hyperinsulinism.

Another cause of hyperplasia is said to be the long-continued excessive ingestion of carbohydrates (Staub-Traugott phenomenon).

Finally, Douglas[5] suggests a stimulating fac-

Table 1. Glucose Tolerance Tests



PRE-OP

POST-OP

	BLOOD SUGAR	
	PRE-OP	POST-OP
FASTING	95	94
½ HR	199	175
1	296	212
2	264	136
3	110	69
4	48	76
5	92	96

tor, such as pituitary hormone, as etiologic in islet cell hyperplasia.

Friedlander[1] lists 22 authenticated cases of hyperinsulinism due to hyperplasia of the islet cells. Ferner and Beek[4] add another case and Douglas[5] still another. In addition, there have been other cases suggestive of this condition but without histologic proof.

In the case presented here there was nothing in the patient's preoperative symptoms or work-up that indicates stenosis of the sphincter of Oddi. Nevertheless, this area was examined at surgery in order to rule out the possibility of an aberrant islet cell adenoma in the region of the ampulla of Vater. The fact that a stenosis of the sphincter was found suggests the possibility of an incomplete obstruction at this level as being a factor in the gradual development of hyperplasia of the islet cells. This might, in other instances, be associated with a chronic or recurrent pancreatitis, although there is no evidence to this effect in this case. In the event that there is any merit to this reasoning, a sphincterotomy might prove of value in preventing further hyperplasia in the remaining pancreatic tissue following resection of the hyperplastic tissue of the tail.

Summary

1. A case of hyperinsulinism due to hyperplasia of the islets of Langerhans is presented.
2. There would seem to be ample proof that such an entity exists as evidenced by reports in foreign journals, although it is generally unrecognized in this country.
3. A possible association of stenosis of the sphincter of Oddi with islet cell hyperplasia is suggested. It is also suggested that, when an adenoma is not found, the sphincter of Oddi be examined for stenosis because of the possible correlation of this with hypertrophy of the islet cells.

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5. Douglas, D. M.: Spontaneous Hyperinsulinism Due to Benign Hyperplasia of Islet Cells, Arch. Dis. Childhood 34:171-173 (Apr.) 1959.
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Is Hypnosis Practical Hypnosis used as anesthesia has an appeal from a physiologic standpoint. If one could eliminate chemical anesthetics, particularly in disease processes for which their use increases the risk, the patient could be greatly benefited. However, it is by no means known that hypnosis can replace chemical agents for all (or many) patients. Certainly the individual difference in ability to be hypnotized must be taken into consideration, and the anesthesiologist undoubtedly would need to be present to give chemical agents in the event of failure of hypnosis. I do not know of any situation wherein surgical anesthesia cannot be produced by one or another of the anesthetic agents. I suspect that many times the desired level of surgical anesthesia could not be produced by hypnosis. Furthermore, it is difficult to see how hypnosis would save professional time. It would be a choice of having an anesthesiologist or a hypnotist, or both, attending in the operating room, unless the procedure is so minor that the physician could do his own hypnosis such as a dentist might.

Surgical anesthesia by hypnosis should probably be reserved for those situations in which the condition of the patient presents undue risks with chemical agents. It may become a useful method in normal delivery. *Donald Hastings, M.D. Hypnosis in Medical Practice. J. Lancet. May 1961.*

Duodenal Obstruction Due to Hematoma —A Case Report

H. E. Spafford, M.D., *De Kalb*

Twenty-one cases of duodenal obstruction due to hematoma have been reported in the literature. The majority have a history of trauma, which might alert the attending physician to think of this relatively rare condition. However, as in this case, with no history of trauma one would not readily think of this possiblity in a patient having symptoms predominantly of persistent vomiting and abdominal pain.

Only after an indefinite period following symptomatic treatment and ruling out more common conditions does one become suspicious of a mechanical obstruction of this kind. The continued intermittent pain, abdominal tenderness without rigidity, and the short intervals between oral intake and emesis then suggest a high obstruction. X-ray of the area with radiopaque media usually reveals an extrinsic defect with little or no contrast media passing distally to the obstruction. It seems only academic that one should label the underlying pathology, for at best, it would be a good guess if one decides upon the diagnosis of obstruction due to hematoma. In view of the nutritional disturbances that accompany a high obstruction, surgical intervention would seem to be the logical treatment.

Case Report

This patient was a four year old boy in apparently good general health, attending kindergarten daily until his acute illness. During the night of Dec. 2, 1960, the child began to vomit and to have periodic abdominal pain, usually prior to the emesis. He did not have diarrhea nor fever and continued the vomiting, which was forceful, until the physician was called on December 4.

The patient was hospitalized and found to be dehydrated and still having intermittent pain and vomiting. The abdomen was tender in the upper quadrants, but there was no involuntary rigidity. A water-soluble radiopaque solution given orally was soon vomited, but in spite of this a diagnostic plate was produced. It revealed a duodenal obstruction in the region of the bulb and the descending portion of the duodenum (Fig. 1, p. 295). Urinalysis was negative except for the presence of acetone on admission. The red blood cell count was 5,140,000; hemoglobin 15.2 Gm./100 ml.; hematocrit 48 per cent; white blood cells 9,100; differential of segmented forms 72 per cent, lymphocytes 24 per cent, and monocytes 4 per cent. Serum sodium was +125, potassium +3.4, and serum chloride —71 millequiv. per liter.

Intravenous cholorides and glucose were given during December 4 and oral feedings stopped. That evening there was a bile-colored emesis, instead of the usually clear vomitus, which was hopefully interpreted at the time to indicate a possible lessening of the degree of obstruction. On the morning of December 5 there was a similar emesis, but a definite mass could be palpated in the right upper quadrant. Since the general condition of the

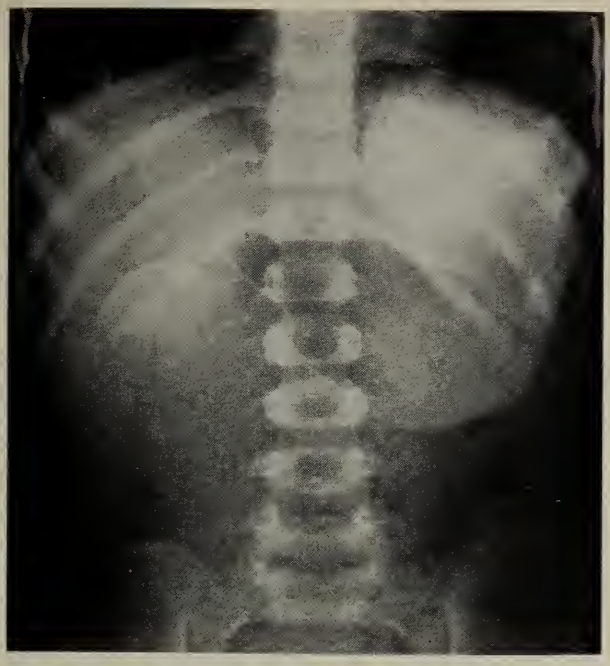


FIGURE 1. Duodenal obstruction in the region of the bulb and descending portion of the duodenum.

patient had improved with fluid and electrolyte replacement, a laparotomy was performed at 1:30 p.m.

A large bluish mass, ovular in form, was apparent at the juncture of the bulb and descending duodenum. The entire small bowel was collapsed and the mesentery studded with enlarged lymph nodes. Frozen sections of tissue near the mass and a lymph node were reported inflammatory. The mass was separated by sharp and blunt dissection but was found to be a part of the duodenal wall; it was then aspirated of approximately 30 cc. of dark blood, opened, and sponged fairly free of clots. A rubber drain was placed in the cavity and brought out through a stab wound laterally. The patient improved rapidly. He had no further emesis. Oral feedings were started in 12 hours and soft foods in 48 hours. The child continued to improve and has been well to this date.

Summary

1. This case report is believed to be one of mesenteric adenitis, probably viral in origin with hematoma developing as a result of hemorrhage into or about a lymph node; trauma was considered as secondary to impulsive vomiting.

2. Apparently all of the 21 previously reported cases of duodenal hematoma with obstruction were considered traumatic in origin.

3. Surgical intervention with evacuation and drainage of the hematoma in the totally obstructed duodenum led to rapid recovery.

Conclusion

Duodenal hematoma with obstruction has been treated by (1) intubation and conservative therapy, (2) by surgery with resection or gastroenterostomy, and (3) by simple drainage of the hematoma. Resection or even gastroenterostomy in the presence of obstruction does not seem sound, unless perhaps there is traumatic damage to the obstructed area. Intubation and conservative therapy in a small child can prove to be radical in the delayed effect on nutritional and electrolite imbalance. I would submit that the treatment of choice for duodenal obstruction due to hematoma, in the absence of irreversible bowel trauma, is surgical drainage of the hematoma.

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Bedtime Coffee

There is a small group of persons who often benefit from taking coffee at bedtime. These are the unfortunate sufferers from angina decubitus —the anginal pain that comes with the patient at rest. Although most patients suffering from angina decubitus will be found to have a myocardial infarction, anemia, or some other acute condition, there are those who have no evident explanation. During the day they will have typical angina pectoris on effort, but are comfortable at rest; yet when night comes, they awaken repeatedly with severe chest pain. Some will benefit from sleeping in a chair and others by prophylactic narcotics at bedtime. With an appreciable number the difficulty seems to be a progressive hypoxia secondary to slowing down of respirations during sleep, and these patients derive much relief from a small amount of coffee taken at intervals during the night. *Coffee at Bedtime for Angina Decubitus. J. Florida M. A. April 1961.*



Professional Associations Now Authorized in Illinois

Walter L. Oblinger, *General Counsel*

With the Passage and Approval by the Governor of S.B. 804 authorizing the creation of professional associations, medical interest has noticeably increased in the possibilities for tax savings by physicians through the use of this mechanism particularly through deferment of income in retirement plans. During the last session of the General Assembly, the Illinois State Medical Society by action of its House of Delegates endorsed S.B. 778, which would have permitted three or more physicians to set up medical corporations to accomplish this purpose. This bill was passed by the General Assembly but vetoed by the Governor on the basis that he had approved S.B. 804, which he felt would accomplish the purpose and have wider application to other professional groups.

While S.B. 804 seems to have taken care of the medical group or partnership, the solo practitioner who does not desire to enter into a professional association will receive no tax advantages through this legislation. S.B. 804 provides that any two or more persons duly licensed to practice a profession under the laws of Illinois may form a professional association, as distinguished from either a partnership or a corporation, by associating themselves for the purpose of rendering professional services and dividing the gains therefrom as stated in articles of association and, provided further, that no professional association so organized under this act could engage in more than one type of professional service and that all members of the association must be licensed to perform the professional service for which the association was formed. The act was very carefully written to comply with as many as possible of the criteria already adopted by the Commissioner of Internal Revenue under the so-called Kintner regulations. These regulations in effect provided that the Internal Revenue Service will treat associations as corporations for tax purposes if they possess most of the indicia of a corporation.

The criteria were (1) continuity of life of the business form, (2) centralization of business management, (3) limited liability of those participating in the organization, (4) free transferability of interest. Without duplicating some of the material which follows, it appears to be the consensus of legal opinion that with the exception of No. 3 above S.B. 804 substantially complies with these criteria and more nearly resembles a corporation than a partnership. However, it behooves any lawyer drafting articles of association pursuant to S.B. 804 to be very careful because the Internal Revenue Service will still reserve the right to pass upon the new association. At this time we know of no approved form of articles of association.

While there appear to be several tax advantages to being declared a corporation for tax purposes, the principal interest seems to center in the use of this mechanism to form pension plans for the deferment of income. The Internal Revenue Service has been most reluctant to approve such plans, as many medical groups have discovered. We would suggest to you that the formation of a professional associa-

tion and the decision to form a pension plan for the deferment of income is a problem which should be given much thought and study.

As you will discover, when you read the articles which follow, there are many problems of a technical nature that should be handled only by experts. Some partnerships are so set up that any transfer of assets to the new profession will create a tax liability if not handled properly. You may find that, unless you have a substantial income, the professional association is not for you. You should also bear in mind that in the establishment of pension plans you will have to take in all employees of the association and that contributions to the plan will vest in the employee.

The outlook for the contemplated association might be such that you would be unwilling to take on this long term burden. Such contributions might offset any gains which might be forthcoming. The Illinois Medical Journal has received a number of articles in the wake of the enactment of S.B. 804. Lawyers, insurance men, banks, trust companies, and actuaries have all appeared on the scene and offered to write articles wherein it is presumed they will extol the virtues of their particular interest.

I have selected two articles discussing S.B. 804; one from a member of the Chicago Bar and one from a member of the Illinois Bar resident downstate. I offer them to you without comment as a service of the Illinois Medical Journal. I make no representation as to the competency of the authors, for any statement of fact or of law, or for conclusions drawn. If you are interested in the possibilities of S.B. 804, I suggest that you consult your lawyer.

Medical-Legal Report

Tax Benefits Available Under New Illinois Legislation

Michael L. Weissman, Attorney, *Chicago*

Senate Bill 804, which was signed by the Governor of Illinois on August 9, 1961, authorizes the formation of "professional associations" pursuant to articles of association. The bill has a broad scope in that it allows associations to be formed by any two or more persons licensed to practice *any* profession. The new law will permit professional men practicing in this state to obtain federal tax benefits heretofore unavailable to them.

The sponsors of this legislation obviously had in mind the so-called Kintner[1] Regulations under Section 7701 of the Internal Revenue Code of 1954 when this bill was drafted. These regulations state those characteristics which an association must possess in order to be classed as a corporation for federal income tax purposes.

Even with adoption of the bill, an association does not automatically qualify for taxation as a corporation by the mere execution of articles of association. The procedure outlined in Rev. Proc. 61-11, I.R.B. 61-18 must be followed. This involves an application to the District Director of Internal Revenue for a determination that the association is taxable as a corporation and requires that the following documents be supplied: (1) copies of the articles of association, (2) copies of the bylaws of the association, (3) copies of the local law governing the status of the association, (4) copies of contracts of employment between the association and its members, and (5) a brief statement as to the status of the association and its relationship with its members.

Assuming that an association successfully qualifies for taxation as a corporation, the question then becomes what income and estate tax advantages are gained thereby.

Pension and Profit-Sharing Plans. An association taxable as a corporation can achieve sub-

stantial tax benefits for its members by establishing a qualified pension trust or profit-sharing plan. Under Section 404 (a) (1) of the Code the association may deduct 5 per cent of the salaries paid during the year to its employees as a contribution to a qualified pension trust. Moreover, under Section 404 (a) (3) the association may claim a deduction of as much as 15 per cent of the salaries paid during the year to its employees when said salaries are contributed to a qualified profit-sharing plan.

The effect of these provisions is that professional men will be able to invest up to 15 per cent of their salaries in qualified retirement plans. What is more, under Section 501(a) a qualified pension trust or profit-sharing plan enjoys exemption from taxation. Thus, the income earned by the contributions to the pension trust or profit-sharing plan will accumulate for future distribution without being diminished by federal income taxes.

Capital gains treatment will be afforded to the distribution of benefits under a qualified plan if the total amounts payable to any employee are paid to the distributee within a single taxable year. Thus, by drawing out accumulated benefits in a lump sum, an association member reduces his tax on such amount to not more than 25 per cent. In addition, if the associlation member makes no withdrawal from the qualified pension trust or profit-sharing plan and makes the benefits accrued thereunder payable on his death to a person other than the executor of his estate, there will, under Section 2039(c) of the Code, be no estate tax on such benefits.

Wage Continuation Plans. If the association has corporate status and the relationship between it and its members is determined to be that of employer and employee, a wage continuation plan may be set up pursuant to Section 105(d) of the Code. This Section allows an employee to receive, free of income tax, up to $100 per week if such amounts represent wages or payments in lieu of wages for a period during which the employee is absent from work because of personal injuries or illness. However, during the first seven calendar days of absence, the employee must be hospitalized at least one day or the exemptive provision is inoperative.

Medical Reimbursement Plans. Another tax-saving feature that may be used by the association is a plan of medical expense reimbursement. The association may, pursuant to Section 105(b) of the Code, agree to reimburse its members for medical expenses incurred by them for the medical care of themselves, their spouses and their dependents. The amounts so paid by the association are deductible, but the reimbursement is tax free to the association members.

Death Benefit Exclusion. Again assuming that the relationship between the association and its members is that of employer and employee, the association may avail itself of the benefits of Section 101(b) of the Code. This Section allows the payment of as much as $5,000 to the widow or other survivor of a deceased member by the association *free of any income tax.*

Group Life Insurance. If the association does not name itself as beneficiary, it may purchase and pay for group life insurance on the lives of its respective members and deduct the premiums paid on the policies. Moreover, the premium payments will not constitute taxable income to the members of the association if the insurance is *term* insurance.[2] It should also be noted that the Internal Revenue Service approved a "split-dollar" plan of life insurance under which the employer paid only that part of the annual premium representing the increment in the cash surrender value of the policy during the policy year, the employee paying the balance.[3] Under such a plan the association's payment of premiums would again not constitute income to its members but would be deemed an interest-free loan. The only stipulation is that on the death of the employee the association should be entitled to receive the cash surrender value of the policy.

Subchapter S. If the association has qualified as a corporation for tax purposes, it will be entitled to exercise the election to be taxed as a partnership under Sections 1371-77 of the Code. In this way the members of the association may enjoy not only the benefits outlined above but also the advantages conferred by the

Subchapter S election, e.g., no tax at the association level and the right of each member of the association to a deduction for his proportionate share of the association's net operating loss, if any.

The association will qualify for the election if:

(1) it does not have more than ten members,
(2) it has no members other than natural persons or estates,
(3) it has no nonresident aliens as members, and
(4) it issues only one class of participating certificate.

If the association were, however, to derive more than 20 per cent of the gross receipts from interest, dividends, rents, royalties, or other passive forms of income, it would lose its qualification under Subchapter S.

Exercise of the Subchapter S election will be primarily beneficial to members of the association having marginal tax rates below the usual 52 per cent corporate rate where the net profits are left in the hands of the association. Where the net profits are distributed, the benefit will extend to members with somewhat higher rates since, in this case, there is no "double tax." The election will also be of substantial benefit to associations realizing losses for a period of years where there is no way of offsetting these losses against other income at the association level but the members involved do have other income which can be offset against these losses.[4]

Conclusion

Illinois has recently joined a growing list of states that wish to enable their professionals to obtain some of the Federal tax advantages formerly reserved to corporations and their employees. With the passage of Senate Bill 804 the availability of these benefits is no longer a matter of conjecture. With careful attention being paid to the requirements of the Kintner Regulations, articles of association may now be drawn which insure professional men of tax treatment more closely corresponding to their needs.

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1. *United States v. Kintner*, 216 F. 2d 418 (9th Cir. 1954).
2. Rev. Rul. 56-400, 1956-2 C.B. 116.
3. Rev. Rul. 55-713, 1955-2 C.B. 23.
4. See, S. Rep. 1983, 85th Cong. 2d Sess. (1958) 87.

Medical-Legal Report

Recent Law Makes Tax-Deductible Pensions Available to Illinois Physicians

J. Elwood Popham, Attorney, *Charleston*

With the Passage of the act to authorize professional associations and its approval by Governor Otto Kerner on August 9, 1961, Illinois now has established the necessary legal framework in which two or more professional people can associate themselves for the purpose of rendering professional services so that they can qualify under Internal Revenue Service regulations for a tax-deductible pension or profit-sharing plan.

Previously, these and other fringe benefits have been unavailable to Illinois doctors. Physicians are prohibited by the Medical Practice Act (Ill. Rev. Stat. 1959, ch. 91, §16 p) from incorporating. The Internal Revenue Service (Reg. §301.7701-2 Associations, commonly referred to as "Kintner Regulations") has ruled that a partnership operating under the Uniform Partnership Act (op. cit., ch. 106½), which is the law in Illinois, cannot qualify as an "association" within the meaning of the Internal Revenue Code.

There should be absolutely no doubt now about doctors as "associates" qualifying for fringe benefits heretofore available only to employees of corporations, i.e., pension or profit-sharing plans, wage continuation plans

for disability, group health insurance, group life insurance, and special nonqualified deferred compensation plans as provided by Revenue Ruling 60-31.

The law in Illinois, together with the Internal Revenue Code, Rules and Regulations, is now clear but not necessarily simple. It will therefore be of utmost importance that you secure the services of an attorney and the services of a health and life insurance counselor skilled in the field of employee benefit plans if your benefit plans are to be well designed and executed to fit your individual needs. Your certified public accountant and trust officer should not be overlooked since they can also render valuable assistance in the area of their special knowledge.

The Internal Revenue Service has recently set up a procedure to be followed by those seeking approval of Kentner-type associations. In certain cases this advance approval may be desired by the association or certain associates before installing the desired plan. This procedure, explained in detail in Rev. Proc. 61-11, generally requires that the request be filed with the District Director of Internal Revenue where the tax return is filed, along with copies of the following: (1) articles of association, (2) by-laws, (3) all other data relevant to the formation and operation of the association, with pertinent dates, (4) local laws relating to association status (in Illinois, S.B. 804), (5) contracts of employment with associates, and (6) brief of its position with respect to the status for taxation of the association and its relationship with associates.

After you organize as associates under the new Illinois law, you can install a qualified pension or profit-sharing plan allowing you the following tax advantages:

1. Contributions Are Income Tax Deductible. (Code §404 (a)(1)).
2. Income from These Contributions Accumulate Income Tax-Free. (Code §501(a)).
3. Death Benefit Is Paid to Your Family, Wholly or Partially, Federal Estate Tax-Free. (Code §2039(c) (1)).
4. Insured Death Benefits Are Income Tax-Free. (Code §101(b)(2) (B)(i)).
5. $5,000 of Non-Insured Death Benefit May Be Income Tax-Free. (Code §101 (b)(2)(A)).
6. Capital Gain Rates Apply to This Deferred Compensation if It Qualifies for Lump Sum Distribution in One Year Whether It Be Paid as Withdrawal, Death, or Retirement Benefit. (Code §402(a)(2)).

Besides securing these valuable benefits for the professional associates, this type of plan will have a beneficial effect on the morale of employees. Regular business corporations have learned through much experience that the security and peace of mind created by these plans will "pay off" in increased efficiency and reduced turnover.

The three basic methods of providing the benefits of a formal or qualified pension plan can be broadly classified as (1) insured, (2) self-administered (or un-insured), and (3) combination plan (some pension plans are partially insured and partially self-administered, the overall program being designated as a combination plan). Since a fully self-administered plan is generally considered advantageous only for very large groups of employees, a detailed discussion of it would be inappropriate in this article.

The insured and combination plans are of two fundamental types — individual policy pension plans and group pension plans. For groups larger than 45 to 50 lives, the group pension method is almost universally preferred today. For groups down to perhaps 20 to 25 lives, both the group and individual policy methods are often utilized, but for groups smaller than this, the individual policy method is the clear-cut choice in most situations. Since this article is primarily concerned with the factors involved in choosing a plan for groups smaller than 20 to 25 lives, the following discussion is limited to the characteristics of individual policy plans, some of the considerations involved in choosing which plan should be purchased, and some guideposts in taking action to gain the tax benefits and estate accumulation benefits of a qualified plan.

The fully insured plan provides death benefits and retirement benefits solely through an insurance contract (usually called a retirement income plan.) From a cost viewpoint, the individual policy retirement income plan is most

attractive for the group that wants a complete guarantee of maximum costs. Under this plan, there is complete merging of the group's experience with the insurance company's over-all experience as to mortality, both before retirement and during the income-receiving period. This means that any fluctuations in individual experience will not materially affect the long term costs of the group.

The individual policy combination plan, introduced several years ago, uses a low-cost policy having some cash value but with a large insurance element which is converted, at guaranteed rates, upon retirement to provide the income benefit to which the employee is entitled. Monies to accomplish this conversion are maintained in a "side fund" which may either be handled by the insurance company, by a trust company, or by the trustees of the pension plan investing in common stocks, mutual funds, real estate, or other investments. Deposits to the side fund are determined on an actuarial basis to accumulate the amounts needed for "cost of conversion" at retirement.

The trustee makes deposits to the side fund and assumes the risk of mortality and of interest earned. If the side fund is not handled by the insurance company, the risk of capital loss is also undertaken by the trustee. However, there is opportunity for capital appreciation in certain forms of investment that would reduce future costs or permit a revision upwards of the benefits of the plan. For these reasons, the combination plan would appear more attractive for groups of over, say, 10 lives. Some plans, however, are being installed for even smaller groups. The choice is solely up to the employing association. Usually, each participant's share of the side fund is not vested with him until actual retirement. Vesting costs are therefore generally smaller, and hence, turnover will be less expensive than under the retirement income plan. This also increases the incentive to stay with the employing association until retirement.

Another point of distinction between the two plans is the amount of death benefit. Under the retirement income plan, the death benefit is established at 100 times the monthly pension with an "increasing" feature in later years, so that by age 65 the death benefit equals approximately 160 times the monthly pension. The combination plan permits greater flexibility in the amount of death benefit. For example, the death benefit could be 50, 75, or 100 times the monthly pension, but the plan does not include the "increasing death benefit" feature, resulting in somewhat lower costs. However, the "increasing death benefit" feature is often more attractive to a smaller group for a sizeable death benefit is provided on a most favorable basis.

It is obvious from the foregoing that the association will want to assess carefully its own needs and those of the participants before selecting a plan. Some of the key questions to be resolved are: How important is cost, both as to initial outlay and guarantees of maximum cost? How willing are we to assume some of the risks of deviation from mortality averages? How willing are we to assume investment risks? How important is the death benefit? What are the estate-planning needs of key employees in the group? What is the importance of cash vesting provisions? How much turnover can reasonably be expected? How many employees will be covered initially? What will the size of the group be several years hence? Do we want to exclude any employees? Can this be accomplished?

A well-conceived and designed plan will prove more satisfactory through the years than one which has been purchased without adequate matching of the needs of the association and its employees with the differing characteristics of the different funding vehicles available. The designing of a plan involves technical concepts that make it difficult for a doctor to arrive at a clear-cut answer. Here is the place where a life underwriter can be of invaluable assistance in advising impartially on the merits of various funding methods, and in tailor-making the plan to the buyer's needs. The underwriter has available to him the technical facilities and assistance of his home office, agency staff, and salaried pension field representatives in analyzing any situation.

More and more, smaller corporations have discovered the unique advantages of a qualified pension plan to accumulate an estate for key individuals and improve employee morale and efficiency. Now that these opportunities are afforded members of the medical profession in Illinois, you owe it to yourself and to your family to look into all of these tax-saving opportunities soon.

Private Medicine and Public Health

Dr. Franklin D. Yoder, *Springfield*

Long Ago Medical Science and public health joined hands in the struggle against disease. Epidemics of disease have yielded to immunizations, drugs, sanitary engineering, and other public health measures. Medical science and public health have made living safe, rewarding, and comfortable.

You may remember that it was only 84 years ago the first public health regulations were adopted in Illinois. That wasn't too long ago, but much has happened since. I try to keep my finger on the pulse of Illinois, but it isn't an easy job.

From the farms to the factories, from rural to global activities — with agricultural and industrial progress and teeming cities and their suburban growth — come most of our modern public health problems.

Medical science and public health methods do achieve victories, but new problems arise. Growth and development always bring demands for protection against new threats and hazards. Air pollution, radiation, and water pollution are the increased dangers to the public's health. And please remember that by "public" I mean over 10 million people in Illinois. "Public health is people."

Physician's Role in Public Health

Today, public health is a recognized specialty of medicine. Every practicing physician should have a knowledge of the goals of public health physicians. However, I do realize the difficulty the busy practicing physician has in finding the time to be familiar with the field of public health and to have an appreciation of the values seen by those of us who specialize in public health.

All of you should be acquainted with the special problems in the public health field. Not only that, you should have sufficient knowledge of preventive medicine to give advice on community health problems.

Why? Because you can't avoid being involved. You are always called upon to assist in public health endeavors — be it the USPHS, your local health department, serving on boards of voluntary health agencies, and hopefully, assisting the Director of the Department of Public Health. You can't avoid it, gentlemen; your community is going to seek your advice in preventive medicine.

Let me say, parenthetically, that you as private physicians share the credit for any benefits Illinois may record in reduced morbidity and mortality. Why? It all boils down to this: Regardless of any of our planned programs it is largely the physicians in private practice who influence the thinking of the people. It is the people coming to you, seeking your advice, your counsel, that will determine an intelligent, public-health-minded community that will enjoy the benefits of public health.

Whether you know it or not, whether you are public-minded or not, you wield an important

Director, Illinois Department of Public Health.

Luncheon address at the annual Secretaries Conference in Springfield, October 8.

influence on your community in health matters. You can't avoid this responsibility. Nothing is more important to me in safeguarding and improving the health of the citizens of Illinois than your support and guidance in our public health programs.

Plans of the Department

And now that I've stopped waving my special flag, you probably wonder what we do in the State Department of Public Health. What are our plans? Be assured my flag waving is sincere. Any effective health service must be geared to the needs of the people. We have to use your knowledge to determine local health needs. And now I wish to speak about the need for improving local health services.

We all know that the American Medical Association and the Illinois State Medical Society strongly support the establishment of county health departments.

In addition, the 1960 White House Conference on Children and Youth and the recent White House Conference on Aging — plus the Illinois Commission for Handicapped Children — have recommended that all the counties in Illinois have local health departments. After all, a local health department is the basic ingredient in the prevention of handicapping conditions and the most essential agency for early case-finding.

Public health agencies have a desperate need for the insights and leadership of the medical profession throughout our network of local communities. Traditionally, there has always been a high degree of cooperation between the Illinois State Medical Society and the Illinois Department of Public Health at the state level. But cooperation at the state level is not enough. Active participation in the communities is needed. It is vital that physicians give leadership wherever they are. Unless they become the heart and soul of the broad public health functions, this service cannot become a mature enterprise reflecting the wisdom necessary to meet the challenges to come, to say nothing of those already upon us.

We in the state health department plan to embark upon an aggressive, coordinated plan to achieve complete local health department coverage for the citizens of our state. To date, population-wise, we have 72 per cent coverage, and county-wise less than 30 per cent coverage. Local health services are available in 30 of the 102 counties covering 72 per cent of the population. These services are provided by 21 full time county or multiple-county and 11 full time city and local district health departments. If you exclude Chicago and Cook County, you will find that 1,560,753, or 31.5 per cent of the people in downstate Illinois are fortunate in having local health services. This leaves 68.5 per cent of the population in downstate Illinois without full time health services. This is a sad picture, and we must do something about it.

Physicians' Aid Needed

We need your help. The medical society should be in the forefront of any local movement to establish county health departments. It seems apparent to me that it is in the interest of the medical profession to take the leadership in promoting county health departments and in guiding the direction of health programs as members of local boards of health. Then, too, it is certainly to the advantage of communities or counties to have physicians encourage the development of public health services, locally administered and locally controlled.

By no stretch of the imagination could we expect the state legislature to appropriate sufficient funds to provide large numbers of state public health personnel to acquire the quantity and variety of health services which should be available to the people.

I often hear this criticism of any program to increase local health services: Why establish more county health departments when you can't get qualified public health workers to staff them? We must have sufficient money to keep salaries high enough to attract good people. But remember, money isn't everything, though it helps, I'll admit. Another thing we must do is conduct good local health programs that are known and recognized across the nation. This will attract well qualified personnel to local health departments.

The important task of providing full coverage for Illinois is possible. It is entirely possible and reasonable, with your understanding and cooperation, to work out a plan to give the downstate area first class local health services. We need to organize 43 county and multiple-county health departments. This would involve the

formation of 18 single-county units, nine bi-county, seven tri-county, six quadri-county, three five-county, and one six-county unit.

To support health services locally, we need a strong state health department, staffed with well qualified public health physicians, health educators, sanitary engineers, consultant public health nurses, nutritionists, public health dentists, veterinarians, and laboratory technicians. I am proud to say that Illinois has such a strong state health department. I can easily illustrate this by mentioning a few of our programs.

For example, Illinois ranks among the highest in the nation in environmental health or sanitary engineering. I'm sure you gentlemen drink water in any of our cities with confidence and without any hesitation because of the safety of the water. The fact that Illinois has been free of water-borne epidemics for many years reflects the constant vigilance of our sanitary engineers. Our environmental health problems are very close to us because, in addition to the water we use every day, sanitary engineering programs include the food we eat, the air we breathe, our shelter, the disposal of wastes, the control of natural hazards, and protection against such man-made hazards as air pollution, radiation, and the contamination of our streams.

Monitoring Fallout

For over six years our department has been monitoring surface and underground waters and the atmosphere to determine the extent of radiological fallout in Illinois. Our air monitor in Springfield is a part of the national network. We have a monitoring station in Metropolis near a uranium hexafluoride reduction plant and one downwind from the Dresdon Nuclear Power Plant near Morris.

Those of you who have x-ray machines are aware of the registration law we administer. Some of you have been visited by our radiation detection survey teams. I hope you give favorable consideration to their recommendations because it is mainly the physician or x-ray operator who receives the most benefit from these recommendations. For example, of the 400 physicians' offices our detection teams have checked, 295 or almost 75 per cent had one or more deficiencies in construction, protective devices or in the operation of the x-ray equipment. We have more than 7,000 radiation installations registered in Illinois, and this equipment is periodically checked for potential hazards.

I will admit that Illinois is weak in the field of air pollution. At the present time serious cases of air pollution are handled by our sanitary engineers under the state's nuisance laws. I hope we can have adequate air pollution legislation and sufficient funds to attract qualified engineers to administer an effective statewide program.

Nursing Home Services

Of special concern to our department are the long-term chronic illnesses, which include heart disease, cancer, and diabetes. Our programs encompass both lay and professional education regarding these diseases, but the biggest problem facing Illinois, and the entire nation, is the large bill for hospitalization. This bill is getting bigger every year. I think we can expect Congress to increase appropriations for the care of the aged and chronically ill in 1962. This will help finance increased community health services for the care of the sick at home. We plan to use the increased funds to develop more nursing home services, to expand and improve homemaker's services, and to promote the development of community information and referral service centers.

I seek your help and support in administering these proposed increased funds for the chronically ill. You are well aware of the advantages to our society in keeping the cardiac, the cripple, the diabetic, the ex-tuberculous, the epileptic, and the dry alcoholic at work productively. The economic burdens of physical impairment are tremendous, and any assault we can make on this problem will help achieve a productive life for many of our citizens.

Almost a million people in Illinois are 65 years of age and older, and I am sure you can see our attendant problems with this aging population. We have made considerable progress.

Illinois was one of the first states to have laws for the inspection, regulation, and licensure of nursing homes. Legislation began as far back as 1945, and since then there has been constant upgrading of standards to insure better care and housing for the elderly. We promote a new concept of nursing homes — those

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especially designed and constructed to take care of the needs of aging persons and give them modern, attractive, homelike surroundings. Of course, rehabilitation is vital in our concept of nursing home care.

In 1959 the Council on Medical Service of the American Medical Association and the American Nursing Home Association jointly agreed on a set of suggested policies for medical care in nursing homes and related facilities. Briefly, this guide states that each patient should have, along with the routine physical examination, an evaluation of his potentialities for rehabilitation, including self-care possibilities, full outlines of treatment, and written instructions for care and medication. We recommend that every nursing home should maintain liaison with local physicians for consultation on medical care and guidance. In fact, every nursing home should have a staff physician, or a group of physicians, to advise the operators on general medical matters.

It goes without saying that adequate hospital facilities are necessary to maintain good health. Our State Survey and Plan for Construction of Hospitals and Medical Facilities, known nationally as the Hill-Burton program, is now in its fifteenth year of operation. Since its inception, 159 projects have been approved for construction, adding more than 12,000 hospital beds in Illinois. You may be sure that a program involving 159 construction projects with a capital investment of more than $358,000,000 has had a great impact upon the practice of medicine in Illinois. The development of these modern hospital facilities has given physicians adequate places in which to work and has increased the scope of their practices.

Services for Physicians

Our hospital licensing program also influences your practice of medicine. The Hospital Licensing Act, passed in 1953, establishes and promotes standards of hospital operation, assuring safe and adequate patient care.

Under the Hospital Licensing Act we inspect and license about 300 hospitals a year. Our hospital regulations are not just a "sanitary code." They cover those things that are basic to high quality patient care: the organization of the governing board, hospital administration, medical staff organization, professional nurse staffing, and medical records, as well as matters of general sanitation and food handling. Since hospitals are the centers for your diagnostic and treatment procedures, you can readily see how significant these programs are to your private practice of medicine.

Another important program provided for physicians is our laboratory services. We have laboratories in six areas of the state: Carbondale, Champaign, Chicago, East St. Louis, Rock Island, and Springfield. These laboratories make a total of nearly a million examinations a year, and 700,000 of them are diagnostic laboratory tests made for physicians, dentists, veterinarians, and health officers in connection with the prevention and control of infectious diseases. The other tests were done in connection with sanitation programs, such as examination of air, water, milk, and other dairy products.

Our laboratories provide a variety of diagnostic procedures not usually available in hospital and private laboratories. Such tests are for viruses, the Sabin-Feldman Dye test for toxoplasmosis (which, by the way, is so difficult that it is performed in only five other laboratories in the country), the treponemal complement fixation test for syphilis, complete identification of intestinal pathogens, and phage typing of staphylococci and other pathogens. In addition, most of the commonly used vaccines and serums are made in our own laboratories for free distribution to physicians.

As you know, a committee of the Illinois State Medical Society has been working closely with our depatment in devising a mutually acceptable birth certificate. The existing supply is dwindling fast, and we expect to distribute the new certificate around the first of the year.

While on the subject of vital records, I want you to know how much we appreciate the support of the Illniois State Medical Society in the passage of a new vital statistics act by the 72nd General Assembly. This is a milestone in improving and modernizing the state's system of registration of vital records. This new act becomes effective Jan. 1, 1962.

In the field of preventive medicine, health departments have been concerned with the con-

trol of communicable diseases for many years, including the provision of drugs and antibiotics to prevent these diseases. Our area of responsibility includes a check on the labeling of all hazardous substances, developing poison control centers throughout the state for the emergency saving of lives, promoting maternal and child health through medical, nursing, nutrition and social work services, and the provision of care for premature infants in centers in Springfield, Peoria, and East St. Louis. In addition to the care in the center, transportation is provided in an ambulance equipped with a portable incubator and oxygen, and care is provided enroute by a nurse skilled in the care of premature infants. Over 1,500 babies are cared for each year in this program.

In the area of tuberculosis control, we assist the physician by advising him of the hundreds of abnormalities found in the course of conducting county-wide chest x-ray surveys. Each survey is arranged after securing the approval of the local medical society, and all abnormalities are referred to the family physician for further clinical study and diagnosis.

Our department operates two tuberculosis hospitals, one in Chicago with 400 beds, and the other in Mt. Vernon with 150 beds. Both of these institutions offer care and treatment equal to that of any sanitorium in the state, and, in addition, serve as surgical centers for those sanatoriums lacking facilities for thoracic surgery.

The state medical society encourages physicians to use the tuberculin test freely in their offices, and the department provides tuberculin PPD.

Chesterton, in one of his famous paradoxes, is quoted as saying, "Whatever is worth doing is worth doing badly." We sometimes seem to adopt this point of view in insisting that inadequate treatment of tuberculosis is better than no treatment at all. Token treatment with isoniazid alone has been prescribed for patients all over the world, many of them with far advanced tuberculosis, extremely poor nutrition, and socioeconomic burdens of crushing magnitude. We will not cure them, we have argued, but a few months of bacteriologic remission and of clinical improvement is justified on public health grounds.

We must now begin to ask ourselves if widespread infection by drug-resistant tubercle bacilli is too high a price to pay for such transitory benefits. What has always been recognized as inferior treatment from a clinical point of view seems now to be losing its justification from the public health point of view. The administration of isoniazid to patients who have no real chance of achieving complete control of their disease with this drug alone may be shortsighted public health practice as well as second-rate medicine.

The state of Illinois provides a subsidy to tuberculosis authorities where funds from local taxation are insufficient to offer care and treatment to all known cases of tuberculosis. The subsidy fund, administered by the department, amounts to $2,600,000 during the current biennium.

Other Health Services

I would now like to mention the zoonoses. In accepting our responsibility for preventing human diseases, we must include human diseases of animal origin. Because the zoonoses are so complex both ecologically and epidemiologically, health departments, animal disease control agencies, physicians, and veterinarians must work together. Some of the interrelationships in animal-human disease need defining, and hazards to the public's health need to be pointed out. It has been suggested by many research workers that a great deal of the physical and mental infirmities of the aged can be traced to some of these diseases of animal origin with long, protracted chronicity. In other words, we all should be working toward developing programs in animal-human disease prevention — a "troika" composed of health officer, physician, and veterinarian.

A step in the right direction is the recently established Zoonoses Research Center at the University of Illinois, the second such center to be established in the world. Here activities will defiine the epidemiology and the public health hazards of the zoonoses. This department, as well as physicians, veterinarians, and animal disease control agencies, will be intimately involved in the work of this center.

In the field of dental health, we also need your support. At the present time, over five million people in 128 Illinois communities are drinking fluoridated water. Another 139 com-

munities have sufficient fluorides occurring naturally in their water to receive dental benefits. Yet there are hundreds of communities that are not benefiting from fluoridation. I think physicians can help a great deal to bring about the acceptance of this public health procedure in fluoride deficient areas of our state. I think you should show your interest to the dentists and offer to support fluoridation programs.

Dental care for mentally handicapped children has been a problem in some areas of the state. Through a postgraduate course sponsored by the department, efforts are being made to qualify more local dentists to render this type of specialized treatment.

We have a Bureau of Health Education which functions in all phases and areas of public health. Millions of pieces of health literature are published; films are provided on most public health subjects; exhibits are made to portray local health situations and needs, and group meetings are organized and conducted.

I would like to mention one other area where we seek your support. In talking with Secretary of State Charles Carpentier a few weeks ago, he mentioned the hazards of allowing mentally and emotionally incompetent people to drive automobiles. He hoped that the physicians in the state would support a program that would keep the mentally disturbed and physically incapacitated from driving cars. I'm sure you will want to back this proposal and report anyone you think shouldn't have a driver's license for either mental or medical reasons. Not too long ago, a deranged patient caused a serious automobile accident, and people were killed.

Russia's resumption of nuclear testing has intensified the public's demand for information on civil defense. President Kennedy asked Defense Secretary Robert McNamara to work with the governors at their conference on September 17. At this conference the governors discussed civil defense programs, including fallout shelter proposals, for submission to the state legislatures. It is planned to develop complementary federal, state, and local programs. Therefore, the state health department will be deeply involved in the planning of health and medical services in our state's civil defense program. We will need well qualified personnel to plan for civilian defense because this is a serious responsibility.

Conclusion

You in the private practice of medicine and we in public health have common interests. We must work together to plan and carry out public health programs that will meet the needs of the citizens of Illinois.

Cardiac Asthma (1) Cardiac asthma is strongly suggested by, (a) rapid fluctuations in weight, (b) significant weight loss coincident with improvement in asthma, (c) moist basal rales which occur only during attacks and are absent between, (d) x-ray of fluoroscopic signs of congestion in the hilar areas with normal shadows between attacks, and (e) a marked fall in blood pressure and pulse rate coincident with relief of an attack. (2) Easily demonstrable left ventricular disease is not necessary to the diagnosis of cardiac asthma, especially in uncomplicated coronary insufficiency and arteriosclerotic heart disease. Left ventricular loads may be difficult to demonstrate in pre-anginal coronary insufficiency. Actually, the first manifestation of coronary insufficiency may be an attack of cardiac asthma. (3) Evidence of left ventricular loads suggests, but does not prove, that an attack is due to left ventricular failure. *Oscar Swineford, Jr., M.D. Cardiac Asthma. South M. J. November 1960.*



Editorials

Study to Identify the Coronary-Prone

A six year follow-up experience of the Framingham (Mass.) study was reported recently.[1] The study represents a search for the factors most likely to lead to the development of coronary heart disease (CHD). The group hopes to uncover characteristics of persons that will be helpful in identifying the coronary-prone individual many years before the occurrence of clinically recognized disease.

It is becoming obvious that multiple interrelated factors are responsible for the development of coronary atherosclerosis. There are many physical, chemical, emotional, social, and environmental factors that play a role. Prospective studies are being conducted in many parts of the country to find important elements of the multifactorial etiology of coronary atherosclerosis.

So far 186 men and women aged 30 to 59 years after entering the study developed coronary heart disease in the six-year period. The over-all incidence was 36.3 per 1,000. In the younger age group males predominated.

Angina pectoris was the initial manifestation in 70 per cent of the women, whereas only 30 per cent of the men exhibited angina pectoris alone. Myocardial infarction or sudden death was the initial manifestation in 70 per cent of the men. Sixty-two and a half per cent of all sudden deaths attributed to CHD in men was the initial manifestation — reason enough to unmask the high risk etiologic factors. The incidence of sudden death was ten times as common in men as in women. Women are more aware of minor changes and more likely to report angina the first time it occurs.

It was startling to find that 44 per cent of those with initial myocardial infarction were not hospitalized, half of them because of sudden death.

About the chemical and physical changes in the etiology of CHD, the authors said: "The well-recognized influence of hypertension and hypercholesterolemia on the development of coronary heart disease is confirmed. It is now demonstrated that these factors precede the development of overt CHD and are associated with increased risk of its development. In addition, it is now demonstrated that the electrocardiographic pattern of left ventricular hypertrophy is also associated with increased risk of developing CHD.

"The magnitude of the increase in risk associated with these characteristics has been assessed. Hypertension has been noted to be associated with a 2.6-fold increase in risk in men 40 to 59 years of age and a sixfold increase in women the same age. With respect to the development of coronary heart disease, hypertension was noted to represent a greater risk factor in women than in men, while elevated serum cholesterol levels contributed only slightly to increased risk among women as compared with men. Elevation of serum cholesterol levels (i.e., 245 mg. per 100 ml. or more) was associated with more than a threefold increase in risk among men aged 40 to 59 years.

"A pattern of left ventricular hypertrophy by electrocardiogram was noted to be associated with a two- or threefold increase in risk of development of CHD at given hypertensive blood pressure levels in men. Combinations of these risk factors (hypertension, elevated serum

1. *Kannel, W. B.; Dawber, T. R.; Kagan, Abraham; Revotskie, Nicholas, and Stokes, Joseph, III: Factors of Risk in the Development of Coronary Heart Disease. Six Year Follow-up Experience, Ann. Int. Med. 55:33, 1961.*

cholesterol level, and left ventricular hypertrophy by electrocardiogram) were noted to augment further the risk of development of CHD. Men 40 to 59 years of age lacking these three abnormal characteristics were noted to have a six-year incidence of coronary heart disease of 35.8 per thousand. When all of these characteristics were present, the incidence rose to approximately 500 per thousand. These risk characteristics were shown to occur with sufficient frequency in the population to merit concern; 8 per cent of men and 11 per cent of women had two or more of these abnormal characteristics. At least one abnormal characteristic was present in over 40 per cent of the population aged 30 to 59 years."

Chicago Throat Culturing Program

The physician charged with the responsibility of management of acute upper respiratory illness in the child or young adult must differentiate in his own mind between a viral or a bacterial infection. To do this he may use both clinical and laboratory methods. Once the diagnosis is established, he must then use specific antimicrobial agents as indicated to eradicate a bacterial infection. The most common bacterial agent seen in an upper respiratory disease is Group A streptococcus. Infections due to this organism are of major concern because of the subsequent development of the nonsuppurative complications, acute rheumatic fever, and acute glomerulonephritis in a certain percentage of untreated or partially treated patients.

During epidemics and in certain population groups, it has been demonstrated that about 3 per cent of untreated streptococcal infections are followed by rheumatic fever. Adequate and early penicillin treatment of a streptococcal infection will eliminate the organism from the throat and prevent most attacks of rheumatic fever. The accurate recognition and diagnosis of individual streptococcal infections and the adequate treatment and the control of epidemics in the community presently offer the first practical means of preventing initial attacks of rheumatic fever.

Approximately 50 per cent of streptococcal infections are likely to escape detection because they are either atypical or asymptomatic. The other 50 per cent can be suspected by their typical clinical manifestations. In the absence of a scarlet-feverlike rash, it is impossible to differentiate many streptococcal infections with certainty on clinical grounds alone. It seems reasonable, therefore, that bacteriologic support and confirmation of the initial clinical impressions by the use of the throat culture is highly desirable. In addition, the recognition of beta hemolytic streptococci on throat culture in patients without classical streptococcal infections has been felt desirable in order to assist the physician in making a correct diagnosis and assuring adequate treatment in a greater number of streptococcal infections.

This approach to the primary prevention of acute rheumatic fever has been given high priority by the American Heart Association Committee on Prevention of Rheumatic Fever. It is felt that the individual physician is responsible and may take the initiative in recognizing and managing streptococcal infections to offer a means of controlling and preventing primary attacks of acute rheumatic fever.

It is recognized that since the introduction of antibiotics in 1945, there has been a steady decline in the attack rate of acute rheumatic fever. However, throughout the country there are still hospital admissions for this disease in a steady number which has not diminished measurably since 1945. It would appear that this minimum attack rate must be approached with a method other than widespread use of antibiotics.

The use of a throat culture to improve our diagnostic acumen is a simple, rapid, accurate, and inexpensive method of detecting a greater number of beta hemolytic streptococci in individuals with upper respiratory infections.

Once the diagnosis of streptococcal infection has been confirmed by throat culture, the physician feels obligated to treat the patient with the prescribed amount of antibiotics as recommended by the American Heart Association Committee on the Prevention of Rheumatic Fever.

About five years ago the Rheumatic Fever Committee of the Chicago Heart Association approached the problem of primary prevention of rheumatic fever. It was recognized that the use of the throat culture as a standard, inexpensive, and widespread tool to the physician

would be a very welcome approach to this problem.

Pilot studies indicated that a messenger service bringing the throat cultures to the health department would be both cumbersome and expensive, a method not applicable to a city-wide approach to throat culturing. During the past 24 months, a mail-in throat culture kit has been developed by members of the committee as well as the laboratory personnel of the Board of Health of the City of Chicago. A feasible method has been developed, which is highly accurate when a dry dacron swab is obtained from the patient's pharynx and is mailed to the appropriate laboratory and inoculated within 24 to 48 hours after the throat culture has been obtained.

Cooperation with the Board of Health of the City of Chicago and the clinical laboratories under the directorship of clinical pathologists of the City of Chicago has resulted in a city-wide program that will offer to the private physician's patients and to the indigent an accurate and simple method of diagnosing streptococcal infections. Physicians may take cultures from private patients, using a kit identical to that of Board of Health, and may send this kit with the inoculated swab to their own private laboratories, either by mail or by having the patients take the culture directly to the laboratory. Results would be either mailed or phoned in to the physician within 24 to 36 hours after the culture has been obtained. A minimal fee for this, which would include only the diagnosis of beta hemolytic streptococci, would enable the physician to use the throat culture freely, easily, and without concern for financial hardship to the patient. The same kits will be used by physicians in clinics for indigent patients and will be mailed to the Board of Health laboratories, which will report the results as quickly as possible to the physician.

It is anticipated that, once the culture has been obtained and is confirmed for beta hemolytic streptococci, a standard method of therapy will be employed and the use of the method will be extended to other contact members of the family. The throat culture would be used for follow-ups and particularly for known rheumatic fever patients and known patients with kidney disease who have been exposed to streptococcal infections.

It is felt that this throat culturing method offers a simple and effective means of detecting beta hemolytic streptococci in individuals with bacterial upper respiratory infections. It will be offered at a nominal cost throughout Chicago to make it available to every physician. This method will facilitate the recognition of most streptococcal infections. It will make clinical medicine more precise, more gratifying, and will aid in the adequate management of bacterial infections.

Target date for the commencement of this service to physicians is Fall, 1961.

Alan C. Siegal, M.D.
Chicago Heart Association

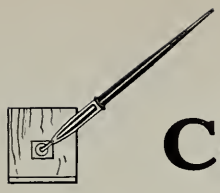
The Basic Question

Colds are common because there are many antigenically different respiratory viruses. This is the reason also why it is difficult to make a vaccine containing antigens for protection against most respiratory infections. The search for an effective vaccine must go on despite this limitation.

But clinicians and virologists have failed to answer one of the basic questions relative to common colds: Why do some people never have a cold whereas others are afflicted repeatedly? Do they have a nasal mucosa that resists the growth or invasion of the virus? Is individual resistance concerned with pH, temperature, or some other physiologic defense mechanism?

Research along this line should not be difficult considering the ease with which colds can be produced in volunteers. Dr. Harry F. Dowling and his co-workers at the University of Illinois have done this by inserting drops containing infected nasal secretions. The colds produced by one secretion had an incubation period of two days, and a typical nasal discharge and obstruction were noted in 97 per cent of the volunteers. The respiratory infection produced by another batch had an incubation period of less than 24 hours, and the clinical picture was typical in only 61 per cent. Sore throat, hoarseness, and cough were present in 38 per cent.

A study of the nature of volunteers' immunity might yield an answer to the basic question.



Correspondence

Comments on Social Security Poll

September 28, 1961

To the Editor:

I am well aware that the following comments on social security, coming as they do after the completion of the poll, will not influence the outcome; however, in the face of a desire to keep the record straight, I felt impelled to add a few omitted details.

Dr. Cross comments that "there is not one iota of a sign that either income taxes or social security is going to go away." That there is more than an iota of pressure against the income tax is evident from Mr. Willis Stone's 24th Amendment, slowly edging in our legislatures. Then there is Frank Chodorov's "The Income Tax, Root of All Evil"; Mr. Fred G. Clark's exposé of the Socialistic 16th Amendment; the various publications of groups like the Foundation for Economic Education, The Manion Forum, The National Review, The Freedom School (Colorado), etc. These constitute more than an iota.

In addition to the increasing pressure against the income tax, Dr. Cross perhaps noted that there is beginning pressure against the social security system. Senator Goldwater made the remark, "I think we should put social security on a voluntary basis" (Chicago Tribune, September 26, 1961). And the Senator marshalls his facts cogently to substantiate this viewpoint.

It is an elementary economic fact that any private company derives its basic stability from its own economic management, and not the government, as maintained by Dr. Cross. There are, of course, certain public (socialistic) enterprise ventures which could not exist without the aid of the government, e.g., the TVA. I am, of course, aware that a stable government is necessary for economic, political, and social progress.

I would qualify the statement made by Dr. Cross that "The reserves for government are its taxing power," the qualification being a *limited* taxing power. Please remember that one of the most important tenets of Marx and Engels was a heavy graduated or progressive income tax and abolition of all right of inheritance.

Alexander Hamilton perhaps spoke more wisely than he realized when he referred to the powers to tax as the power to destroy. Excessive taxation was an important factor in the decline and fall of civilizations. Few will deny that our present tax rates stifle initiative and above-average performance.

I am sure that most people are by now aware that "As a matter of fact, social security does not provide insurance. The contributions are called premiums, but they are just taxes. Those who pay them acquire no rights . . . the benefits, when and if they are paid, have no significant relation to earnings, and still less to the premiums paid. . . . Most of the money now (1956) being paid out by social security is, in fact, relief. Those who get it did not pay for it, and millions do not get what they paid for, or were told and believed they paid for. The benefits come out of the wages of working people, not out of the 'reserve fund.' The trust fund account called by that name is neither a fund nor a reserve." (Dillard Stokes Social Security — Fact and Fancy, Henry Regnery, p. viii, 1956).

Rep. Gordon H. Scherer of Ohio (AMA News, April 4, 1960) wrote ". . . very few taxpayers realize that practically none of their social security payments are being . . . set aside and invested for them as insurance companies are required to do; that their contributions will be used or paid out long before the time they will start to draw benefits."

In its first quarter century, social security took in $70 billion. It paid out $50 billion of that and has $20 billion of government bonds in the "reserve." Against that $20 billion there are

obligations, at the present rate of benefits, of $360 billion. The truth is that the administration will have to pay out $18 for every $1 it now has in the "fund."

Thus, it is apparent that there are some grave doubts of the solvency of the social security mechanism, particularly so in the future, and even with increased rates becoming effective. Furthermore, the cost of the benefits to accrue to future beneficiaries is now far in excess of the value of such benefits; this has been omitted by both discussants in their articles in the Illinois Medical Journal.

As George E. Immerwahr, who spent seven years on the staff of the Bureau of Old-Age and Survivors Insurance, points out, "This does not mean that the OASDI system is insolvent. Instead it means that its solvency depends not on the tax money it has already collected, but rather on the ability to continue to impose social security taxes in the future on the millions of younger people who are still at work, and it therefore depends in great measure on the future productivity of these younger people. Their OASDI benefits in turn depend on the future productivity of still later generations."

According to Actuarial Study No. 48 of the Social Security Administration, the new entrant into social security is scheduled to pay $1.69 for every $1 promised in benefits. No wonder Paul L. Poirot ("Social Security's Salvage Value," The Freeman, p. 11, March 1960) writes, "If you're buying social security, it's not a good deal to be a young person. In fact, it's an exceedingly raw deal . . ." And, mind you, this information comes from the actuaries of the Social Security Administration! It is not their business to paint the picture any worse than it really is.

I would be most interested to know the frank opinion of the Insurance Institute regarding the statement that U.S. Government Bonds "have been the backbone of insurance company reserves"; perhaps it is literally true ("have been").

Dr. Cross, I am sure, is aware that there are many insurance (disability) plans available for the periods in life when a loss of earned income occurs.

I have also seen many older attorneys, physicians, etc., who continued trying to practice from force of habit (not from lack of funds as stated by Dr. Cross), and in the presence of waning mental powers.

Physicians who are interested in social security primarily because of survivorship benefits should realize that those benefits have many gaps and deficiencies which can be avoided in private insurance plans. For example, a widow with no children under 18 receives no survivorship benefits until age 62. Family survivorship benefits terminate when the youngest child becomes 18, leaving a no-income gap until the widow reaches age 62. A widow's survivorship benefits stop if she remarries, and they are reduced if she or her children enter substantial gainful employment.

About those physicians who do not have enough funds to retire, let me say that a certain part of our yearly medical society dues is used to fill the needs of those physicians who are unable to practice any longer and are without funds. I am well aware that there are occasionally mitigating circumstances (e.g., inflation, unforeseen calamity, etc.) which precipitate an honorable man into a fiscal abyss. But then, there are those who do not believe in saving for the unexpected illness or the debility of old age. Thus, Nathan Shock in "Trends in Gerontology" (p. 44, 1957) states that "The belief that each person should set aside, from current income, sufficient funds to provide for old age is attractive but unrealistic." Another author, J. P. Drake, in "The Aged in American Society" (p. 4, 1958) similarly calls savings for old age a "social myth."

About the sample survey (quoted by Dr. Cross) conducted by the Social Security Administration of the number of physicians on social security, I quote James P. Gossett from the March 18, 1960, issue of "The American Statesman." "A poll (or survey) can mean much, or it can mean nothing, or it can actually be arranged (deliberately or accidentally) to produce whatever results are desired by those conducting the poll (or survey). Mathematicians state that it is an impossibility for an impartial poll (or survey) to be managed by prejudiced agencies." I am sure all physicians are aware of this, because of their acquaintance with double-blind methods of the study of drug effects. Even *such* a method fails occasionally.

The Committee on Social Security for physicians is a New York organization highly biased

in favor of social security for physicians. They have made unsubstantiated charges that "Illinois and other state medical societies refuse to poll members on social security" (March 1960). They have arranged with the "Honest Ballot Association," also of New York, for the polling of physicians in Illinois. These organizations had, of course, no interest in the outcome of the poll! They quite naturally reported their poll was in favor of social security. I had some limited correspondence with both organizations, but I could not get any information as to the source of their funds.

I have not been an enthusiastic supporter of *Medical Economics* (quoted by Dr. Cross) or their surveys. The policy of this magazine has been to sensationalize some controversial or obscure problem. When it comes to a rebuttal, it has been their editorial policy to relegate critical dissents into a very brief and obscure notation under the Letters to the Editor Column. I have had such an experience with them in the so-called Samaritan legislation.

It seems apparent that the validity of the findings of the Social Security Administration and *Medical Economics* is somewhat dubious.

The best analysis of the social security system is, in my opinion, that of Mr. R. M. Peterson of the Equitable Life Assurance Society of the U.S. (The Coming Din of Inequity, J.A.M.A. 176: 34, April 18, 1961). He justly criticizes the system but also offers constructive recommendations for its fiscal maintenance. If these recommendations are not heeded then "The towering social security structure . . . will fall flat on our posterity." I am afraid that from the deluge of recent proposals that *will* be its fate.

Active support by the medical profession of compulsory coverage would make the profession vulnerable to the charge that it is willing to accept a little bit of socialism for personal gain but is opposed to other bits of socialism designed for the general public. It appears that the social security system is being utilized as the mechanism through which the proponents of socialized medicine hope to accomplish their objective.

I had hoped that more physicians were aware of the distortions and misrepresentations of the social security program. I am amazed at the discrepancy when I read the notices of the administrative OASDI officers to laymen and their briefs in court. Such terms as "insurance," "the insured," "the insured status," "time tested," "tried and proved," repeatedly creep into their publications.

A great danger to the system and the millions who look to it for a base of retirement and survivor income is the threat posed by the possibility of future Congressional action radically enlarging tax costs. We have put off into the future the real burden of taxes to support the program.

I am well aware of two sides to most debatable issues, but I cannot see two sides to the social security system for physicians. I firmly believe physicians should remain the beacons of private individual responsibility. Physicians should oppose big government and stealing from Peter to pay Paul, which is what "social security" is becoming.

Sincerely yours,
Edward Palmer, M.D.
Berwyn

Journal Complimented

September 27, 1961

Dear Dr. Van Dellen:

This letter is to compliment you for the exciting improvement in the ILLINOIS MEDICAL JOURNAL since your editorship.

The Journal has become instructive and interesting.

Best wishes,
Eugene F. Traut, M.D.

For the Record on H.B. 514

Mr. Bob Cole, Executive Director
Illinois Association of School Boards
Springfield

Dear Sir:

It has been called to my attention that your association issued a legislative bulletin No. 198 dated August 25, 1961, wherein you make the following statement concerning House Bill 514:

"House Bill 514 requires new school employees to submit evidence of physical fitness. The school board may require the same from all employees, may designate the physician and if they do, they shall pay for the examination."

You are apparently not familiar with the legislative history of H.B. 514. The bill originally was written to the effect as reported by you. However, when the bill reached the Senate the Illinois State Medical Society introduced an amendment removing the right of the school board to select the physician for the employee, gave the employee free choice of physician and went on to define the word "physician."

In the light of this amendment which was adopted and which is now part of the bill as signed, we believe that your statement is misleading and inaccurate. The principle of free choice of physician is most important to the medical profession and, accordingly, we are requesting that you withdraw this statement and take steps to correct it.

Very truly yours,
Walter L. Oblinger
General Counsel

Extension of Military Duty

September 26, 1961

Dear Mr. Richards:

The retention of certain servicemen beyond their normal date of expiration of active duty tours is essential for augmentation of the Uniformed Services, called for by the President. Implementation poses many problems. Among them is the valid identification of the extendees' dependents who will remain eligible for certain benefits while their sponsors remain on active duty.

The extension of tours of duty may result in some dependents being without a valid Identification Card for some time. The basis of identification is the Uniformed Services Identification and Privilege Card (DD Form 1173). Each card carries an expiration date of eligibility. This date, in the case of dependents of noncareer personnel, is the same as the expected expiration date of the sponsor's tour of active duty.

In the past, the "expiration date" on the ID Card has been the governing factor in determining that eligibility still exists. Since the involuntary extension of the tours of duty of many servicemen is effective almost immediately, the probability exists that some still-eligible dependent wives and children may apply for civilian medical care to which they are still entitled. They may not, however, have in their possession the required proof of their eligibility.

No change is contemplated in the provision of our contract which states that claims may not be processed for payment until the dependents have proven their eligibility to receive care. Service personnel are being advised that it is their responsibility to take necessary action to "up-date" the evidence of dependents' eligibility.

It is most probable, however, that some dependents will be in need of authorized medical care from civilian sources prior to the time this action has been completed. In such cases, the dependent has been instructed to explain the situation to the physician and hospital authorities. They have been advised to present, if available, some tangible evidence such as allotment checks, official orders, directives, or personal letters which state the pertinent facts to the physician or hospital to help support the dependent's claim of continued eligibility.

This office is not empowered to broaden the "good faith" aspect of our contract. The number of dependents temporarily "unidentified" who require medical benefits will not be large.

In view of the situation at hand, I would appreciate your assistance in encouraging physicians and hospitals to exercise patience and understanding during the next several months when their services are requested by dependents of these extendees.

I must emphasize, however, that no claims may be processed for payment unless the dependent has provided a valid DD Form 1173 or a statement of eligibility as required by our contract and as outlined in ODMC Letter No. 1-60.

This information is being furnished to all contractors and to the editors of leading medical and hospital journals. We would appreciate it if you could publish a copy of this letter, or an extract of the information in the next copy of your Medical Society journal or any other news media which is circulated to your membership.

Sincerely,
W. D. Graham
Brigadier General, MC, USA
Executive Director



at the EDITOR'S DESK

Dads and Juniors—by Adoption

Boys are more popular than girls — for adoption. According to Dr. L. L. Fatherree, there were 6,177 adoptions reported to the Illinois Department of Public Health during the past fiscal year. Approximately 85 per cent of these youngsters were adopted prior to age 10, and more than one third went into homes where there were other children. Effective last year, the adoption law of Illinois permits the adoption of adults, and there were 62 persons over age 20 for whom notices of adoption were received by the department. Men (or vice versa) — if you can't marry them, adopt them.

Can You believe It?

The results of some surveys are too fantastic to believe. For example, a news release from the Public Health Service states, "During the year ending June 30, 1960, illness and injury caused the American people to stay home from work, stay in bed, or otherwise cut down their usual activities for an average of 16 days per person, including six days of bed disability."

Most physicians will doubt that the average is this high among their patients. On the other hand, the conclusions are reached through nation-wide household interviews of a representative sample of the population. The information is confidential, and only statistical totals are published. It does not include persons confined to long-term institutions. The only answer, in my opinion, is that the number of days of disability includes the millions of oldsters — who are retired or awaiting retirement and stay at home or in bed 365 days a year. It may also include the wives, which automatically doubles many governmental statistical reports. And to these we can add the millions of poachers who get nervous when they work and blame their health for time off.

Insecticide Affects Wild Life

Studies on the control of pest insects and plants produce strange side effects on wildlife. At the American Chemical Society a group from Patuxent Wildlife Center in Maryland recently reported on the toxicological effects of Kepone on quail and pheasants. The authors summarized their findings as follows: "Kepone, which is being tested for control of imported fire ants, is moderately toxic to quail and pheasants. Birds will survive for extended periods when fed diets containing 100 ppm (about 3 ounces per ton of feed), but die when fed diets containing higher concentrations or when the daily intake of Kepone exceeds 25 mg./Kg. Feeding of diets containing sub-lethal amounts of the insecticide resulted in abnormal coloration of feathers of males of both species. Plumage of male quail that had been fed Kepone during the growth period resembled that of females, and no viable chicks were produced by birds fed 50 ppm prior to and during the breeding season. Quail fed at levels of 1, 5, 10 or 25 ppm produced some chicks (about 60 per cent of number from birds on insecticide-free diets), but nearly 20 per cent of these chicks were crippled or defective.

"Feeding of Kepone (25 ppm) to pheasants resulted in loss of characteristic markings of males, and sharp reductions in reproductive

success. Birds fed at this level prior to and during the breeding season produced only 0.7 chick per hen, whereas birds fed insecticide-free diets produced 13.7 chicks per hen. Autopsy and histopathological examination of these birds showed damage to, or abnormalities in, the livers and testes."

Endemic Goiter

The director of the Pan American Sanitary Bureau informs us that goiter is endemic in all countries of Latin America with the exception of the Caribbean islands. The disease is a definite problem when the rates reach 10 per cent within a country. In some parts of Latin America the prevalence is well above 50 and sometimes as high as 90 per cent. It is generally believed, according to the bureau director, that there are no less than 30 million goiter sufferers throughout the hemisphere.

Ulcer Rate Up

The National Health Survey estimates that 2,440,000 people in the United States have peptic ulcer, an average of 14.4 per 1,000 population. This figure is based on data collected in household interviews during July, 1957, to June, 1959. A similar survey made in 1935-36 found that the prevalence rate was 2.6 per 1,000 or one-sixth that of the present rate. Are we getting soft, or perhaps taxes are too high, or the Russians are becoming too tough?

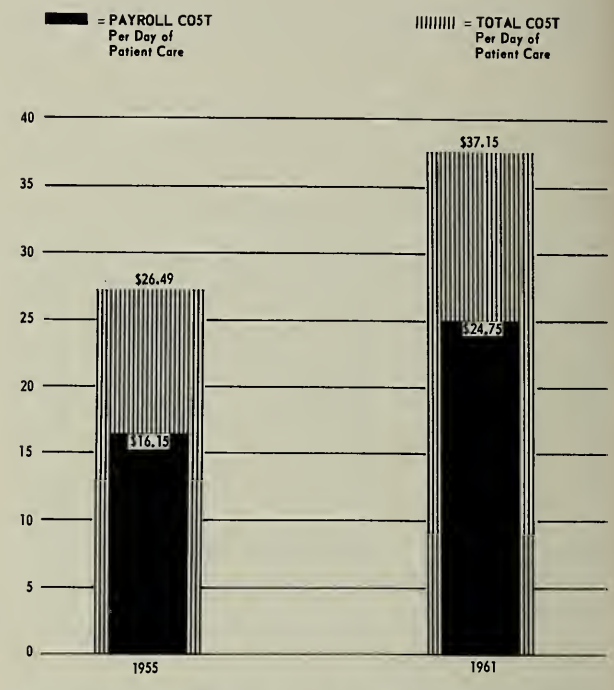
Hospital Costs in Chicago

For the highly-skilled care they receive in Chicago hospitals, Chicagoans today are paying an average of $1.55 an hour, according to a September report of the Chicago Hospital Council. This is an increase of just $.45 an hour over the last six years.

The cost of a day of patient care in Chicago short-term general hospitals is $37.15. In 1955 the cost was $26.49, or an average of $1.10 an hour.

The increase of $.45 an hour over a six-year period is credited in large part to increased payroll costs.

Hospital salaries are now more commensurate with the skills and professional training needed by employees to keep pace with the rapid changes in medical care and are only $1.75 less than the total cost per patient day in 1955. The report shows that payroll expenses today account for 66 per cent of each hospital dollar.



AVERAGE COST of patient care in general short-term hospitals in Chicago, 1961

An average of 1,989 persons daily are admitted to Chicago hospitals, an increase over last year of nearly 100 patients per day. There were 726,181 patients admitted in 1960 as compared to 693,976 patients admitted in 1959.

Youth Fitness Program

President Kennedy's Youth Fitness Program, outlined by Charles B. (Bud) Wilkinson, special consultant on Youth Fitness to the President, consists of five recommendations:

1. The preschool physical appraisal of children be broadened to include screening tests for strength, agility, and flexibility. These tests can be given in less than a minute and in a very small space.

2. Pupils who fail the tests for strength,

agility, and flexibility be required to participate in progressive developmental exercises and activities designed to build up muscular structures and enable underdeveloped students to meet minimal fitness levels.

3. The screening tests be repeated every six weeks until all students reach minimal levels. Students with health limitations that preclude vigorous participation would be put on a program consistent with their physical condition. All medical and health needs should be attended to, of course.

4. All students spend a minimum of 15 minutes per day participating in sustained conditioning exercises and developmental activities designed to build vigor, strength, flexibility, endurance, and balance. This, of course, is part of a broader physical education program.

5. Students be given a comprehensive test at the beginning and end of the semester. The first test would establish their status and perhaps motivate them to improve their physical condition. Parents would have a clear understanding of where their child stands in the physical fitness scale. The second test would measure the child's progress made during the semester.

The American Medical Association pointed out it is important that each school undertaking Wilkinson's fitness program make certain that it is carried out under the supervision of a physician. Careful preliminary physical examinations to make certain that there are no contraindications to physical training are urged for each student.

Statistical Corner

The rate of accidental deaths has decreased in recent years in every geographic division of the country, according to Metropolitan Life Insurance Company statisticians.

Greatest improvement was shown in the East North Central area, where the accident death rate fell from 61.8 per 100,000 population in 1949-50 to 50.1 in 1957-58. This decrease was about one-fifth, or nearly twice the relative reduction for the whole country, they report. Second best was the Pacific division, where the rate decreased 14 per cent.

In contrast, seven states — all in the South and Southwest — recorded increases in accident death rates during the eight-year period.

The rate of fatal falls diminished by about one-fifth across the nation but continued highest in the Northeast, where the proportion of older people in the population is high.

The frequency of drownings dropped by 12 per cent, but the trend varied markedly among geographical divisions. The greatest relative improvement occurred in the northeastern and midwestern sections, while the rate increased in a belt of states extending southward from Tennessee and North Carolina and westward through Oklahoma.

Death rates from fire and burns from other means decreased by as much as one third in the Mountain area and one fourth in the West North Central and Pacific divisions. However, the trend has been upward in many southern states where the number of such deaths has long been relatively high.

The mortality rate increase in a majority of states from motor vehicle accidents is in sharp contrast to mortality from other major causes. The rise was most marked in Louisiana, where it jumped by one third during the eight-year period. The rate changed little in the Mountain states, where it is higher than in any other geographical division. More than 40 persons per 100,000 population were killed in New Mexico and Nevada in 1957-58.

Only in the East North Central states did the rate of motor vehicle fatalities drop materially. The highest reduction — one-fifth — was recorded in Michigan, the statisticians concluded.

The Count on Catastrophes

According to Metropolitan's Statistical Bulletin there were 23 major catastrophes in the United States during the past two decades. A catastrophe is defined as an accident in which five or more people are killed, and a major catastrophe or disaster is an accident taking 100 or more lives. The toll exceeded 4,300 lives. Two fifths were caused by fires and explosions while an equal proportion resulted from natural disasters, very largely tornadoes, hurricanes, and floods.

The three greatest disasters were the Texas

City fire and explosion (561), the fire in a Boston night club (492), and hurricane Audrey (395). Catastrophic accidents of all types took about 27,000 lives during the past twenty years; 1947 was the worst year with 2,000 deaths.

Fires and explosions ranked first with about 7,600 deaths.

Motor vehicle accidents ranked second with slightly more than 6,000. About 3,500 lost their lives in plane catastrophes. If the present air transportation mishaps continue, the figures will change considerably.

Hospital Guide

Did you know that: (1) More than 80 per cent of all hospital admissions are to hospitals accredited by the Joint Commission on Accreditation of Hospitals.

(2) Only a moderate majority (54.4%) of all hospitals are accredited but account for 83.6 per cent of all admissions; 85.7 per cent of all hospital births; 61.7 per cent of all beds; 60.5 per cent of the average daily number of patients; 80.7 per cent of all hospital employment; 81.8 per cent of total expense for operation of all hospitals, and 78 per cent of all hospital assets.

(3) Admissions reported by listed hospitals rose to a record high of 25,027,152 in 1960, an increase of 6 per cent over the 23,605,186 of 1959, the Guide Issue shows.

(4) The ratio of admissions to population also increased sharply—from 133.7 per 1,000 population in 1959 to 139.1 per 1,000 for all hospitals. For nonfederal short-term hospitals the ratio increased from 122.4 to 127.7 per 1,000 persons.

(5) The average number of patients in all hospitals each day rose to 1,401,873 in 1960, compared with 1,363,217 in 1959; these patients occupied 84.6 per cent of all beds set up and staffed for use.

(6) Total assets for all listed hospitals increased by more than a billion dollars to a new high of $17.7 billion. At the same time, total expense increased more than $600 million to $8.4 billion. Payroll expense increased to $5.6 billion, accounting for two thirds of all expenses.

(7) Total expense per patient day averaged $16.46 for all hospitals. The voluntary short-term hospitals led in costs—$33.23 per patient day—while the nonfederal psychiatric group had the lowest—$4.91 per patient day. Patients in nonfederal voluntary short-term hospitals paid an average of $31.51 per day for their care, an average of $1.72 less than it cost the hospitals to care for them.

(8) There were more than a million and a half full-time workers in all listed hospitals, averaging 114 employees per 100 patients, a rise of two over 1959. For voluntary short-term hospitals, the ratio was 232 employees per 100 patients, an increase of three over 1959.

(9) More than half of all U.S. hospitals were voluntary hospitals operated not for profit by churches and nonprofit associations. Slightly more than 14 per cent were proprietary (operated by an individual, partnership, or corporation for profit), and nearly 34 per cent were operated by agencies of federal, state, or local government.

This and other information can be found in the annual Guide Issue of *Hospitals*.

The Killers

Approximately 575,000 people a year die before reaching age 65, not counting the toll in the first year of life. This is more than one third of all deaths, according to Metropolitan Information Service. Accidents head the list of causes of death among children and young adults; cancer, mainly leukemia, ranks second as a killer at ages 1-24. But between 25 and 44, the cardiovascular-renal diseases outrank all among men. Cancer is the culprit in this age group among women. accounting for twice as many deaths as heart disease. These two diseases also take most of the lives of those 45 to 64 years of age—roughly 400,000.

Witch Doctor's Secret Revealed

An old African rat poison (ratsbane) was synthesized by chemists recently. It is extremely toxic to all warm-blooded animals and was used as a witch doctor's secret poison for many centuries. It killed rats and was used as an arrow poison and a fatal contaminant in enemy water supplies. Paralysis of the lower limbs is one of the characteristic symptoms.

Pharmaceuticals

Renese is Pfizer's new oral diuretic and antihypertensive agent. It is known generically as polythiazid, and the primary action (as with other thiazide diuretics) is to enhance the excretion of sodium and chloride. The company claims that more than seven times as much sodium is excreted as is potassium with Renese and that this favorable balance of salt excretion with Renese often will permit more liberal salt intake, and thus provides greater protection from alkalosis caused by low serum sodium and chloride levels. No mention is made of excessive excretion of potassium from the body leading to hypokalemia. This complication must be kept in mind whenever those receiving a thiazide diuretic complain of bitter taste, thirst, gastrointestinal symptoms, weakness, and malaise.

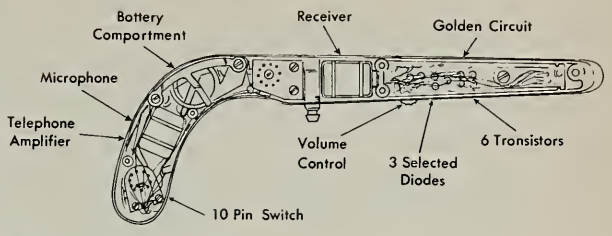
Pfizer has deleted "Cosa" prefix from their line of antibiotics. The change is in labeling only; product ingredients of Terramycin, Tetracyn, and Signemycin remain the same. "Cosa" was the shortened name for glucosamine, and there was no need to retain the prefix because all of Pfizer's oral broadspectrum antibiotics will contain glucosamine. The two forms which did not contain this substance have been dropped.

Mono-Kay is Abbott's new synthetic vitamin K_1, a specific agent for the prevention and treatment of hypoprothrombinemia. The product can be administered orally, intramuscularly, or intravenously depending upon the emergency.

What's New

A new, six-transistor eyeglass hearing aid, said to be the world's most powerful, with new, adjustable templettes has been introduced by Otarion Listener Corporation, Ossining, N.Y., originator of the eyeglass hearing aid.

The new hearing aid, the Super 9, weighs less than ⅔-ounce. It can operate with an Eveready S-76 silver oxide battery for additional gain and power to cover extreme hearing losses ranging from 40 to 85 decibels or with a 675 Mercury battery for those who do not require the ultimate in output.



EYEGLASS hearing aid.

From Manpower to Motor

Physicians of Elkins Park, Pa., use electric carts at golf and also to transport patients and themselves between their three main hospital buildings. A three-wheel vehicle, the model 734 Cushman Truckster, operates in the 300-foot long tunnel that connects these buildings. Patients were transferred previously in wheelchairs, but the method proved too slow and inefficient because one hospital orderly was required with each patient. Then they tried a station wagon, but patients had to go up and down steps and were subjected to inclement weather. The Truckster solved the problem and rightly so. The institution is called Rolling Hill Hospital.



BECAUSE OF ITS easy maneuverability, electric-powered Truckster is able to position itself near elevators for patient pick-ups. With its 80-in. turning radius, this can be performed even by inexperienced personnel.

Book Reviews



Clinical Applications of Cardiopulmonary Physiology. M. Henry Williams, Jr., M.D. $7.50. Pp. 233. New York, Paul B. Hoeber, Inc., 1960.

During the past decade rapid advancements have been made in the diagnostic evaluation and treatment of various cardiovascular and pulmonary lesions. To those intimately concerned with the field, the newer diagnostic technics, their value, and application, are everyday tools. However, for many physicians the practical application of these physiologic studies remains obscure. Dr. Williams has presented concisely the various tests and their usefulness now routinely employed by most cardiopulmonary laboratories. These tests include right heart catheterization, left heart catheterization, cardiac output, arterial pressure, maximum breathing capacity, spirometry, bronchospirometry, lung compliance, lung volume and mixing, arterial blood gases, diffusing capacity, and exercise tests.

The actual technics for performing these physiologic studies are only briefly outlined, and one of these tests must consult other references for the precise technics. However, this does not subtract from the value of the book since it was the intent of the author to present these physiologic tests in the light of normal and abnormal cardiopulmonary states encountered by the clinician in his practice.

To accomplish this end the author presents the physiologic evaluation of respiratory and circulatory functions in the normal state, in heart disease, (both congenital and acquired), and in diseases of the lung, the airways, parenchyma, chest wall, and pulmonary vascular system. Additional chapters cover heart failure, physiologic considerations in thoracic surgery, hypoxia, hypoxemia, and cyanosis, dyspnea, and muscular exercise.

No attempt is made to review the literature completely or to supply an exhaustive bibliography of the subjects covered. Rather, the author presents the material to guide the physician in deciding which patients need these studies and how to interpret them when the results are obtained. The book may be recommended for the student, intern, and general physician.

Thomas W. Shields, M.D.

Curable and Incurable Neurotics. Edmund Bergler, M.D. $6.95. Pp. 453. New York, Liveright Publishing Corporation, 1961.

The author has written several psychiatric books of interest to both laymen and clinicians. This book is mainly a compilation of the author's ideas and experiences with patients diagnosed as neurotics but not "cured" by other doctors, including psychoanalysts. He attributes the reason for this state of affairs mainly to "malignant psychic masochism" which is not always recognized, and states that these patients are most likely psychotic more than neurotic. He feels that he has been able to help them through "deeper analysis." The author ends the book by stating, "It must be admitted that we still have

a great deal to learn about the unconscious mind, and only naive people say that their learning days are over."

Though his ideas and descriptions are interesting, they would not be generally accepted by all psychiatrists; however, the book may be of interest to some eclectic psychiatrists as well as some psychoanalysts. It would be of no value to the lay individual.

Alex J. Arieff, M.D.

PATHOLOGY OF TUMOURS. R. A. Willis, M.D. Ed. 3. $21. Pp. 1,080. Washington, Butterworth, Inc., 1961.

The third edition of "Pathology of Tumours" scarcely needs a new review, for the excellence of the book was clear in the first edition and Professor Willis has maintained this excellence in the two succeeding editions. Without question the book is the foremost work of its kind in English, or for that matter of that in any language. No other book ranges so widely over the field as this one. All aspects of existing knowledge of the pathogenesis, epidemiology, experimental production, and clinical and pathological characteristics of known tumors and tumor-like conditions are considered, both from general and specific points of view.

Professor Willis has made changes in many of the chapters of the new third edition and has added to the text or rewritten the sections on: the experimental production of tumors, animal tumors, carcino-sarcoma, epithelial tumors of long bones, the congenital epulides, bronchial carcinoma, syndromes associated with pancreatic islet tumors, arrhenoblastoma, dysgerminoma, infantile testicular carcinoma, hemangiopericytoma, chemodectomas, embryonic tumors of the liver, and the cardiovascular lesions associated with malignant tumors. Special attention has also been given to the cytologic diagnosis of tumors.

As in previous editions of the book, the author while aiming at a useful general outline of each topic, has to a large extent used his own material as fully as possible and mentions only those papers of other authors that he himself has read. However, Professor Willis seems to be very widely read indeed. These features make the book a personal one with a provocative and individual flavor which is intensified by the author's lucid and concise way of writing. His analysis of many of the current views on the nature of some tumors, particularly the debatable ones, are critically made and tested in relation to his own experience and thus are sometimes stimulating. All this makes for most interesting reading, and one cannot possibly come away from the book without having his thought processes put to use.

The book is well produced and offers good value for the money. It has many well chosen references to the literature, a useful index, clearly printed pages free from typographical errors, and informative, well reproduced illustrations. I have found it a most valuable book over the years and am glad to have a copy of the new edition.

William B. Wartman, M.D.

CLINICOPATHOLOGICAL CONFERENCES OF THE MASSACHUSETTS GENERAL HOSPITAL. Edited by Benjamin Castleman, M.D., and H. Robert Dudley, M.D., $12.50. Pp. 295. Boston, Little, Brown and Company, 1960.

This text contains 50 selected medical cases presented at weekly clinicopathological conferences at the Massachusetts General Hospital from 1936 to 1959. Each case follows a uniform chronological order of presentation, including clinical history, differential and clinical diagnoses, discussant's diagnosis, pathologic discussion, and anatomical diagnosis. Frequently, current comments by the original discussant or another authority have been added after each case.

Cardiovascular diseases, endocrinologic and metabolic problems, and renal diseases are well represented in the series of cases. The discussions by leading medical authorities provide a rich variety of viewpoints and a wide range of possible diagnoses. The pathologic discussion plays its usual important role of clinicopathological correlation.

The table of contents and index are so arranged that any case can be selected on the basis of its clinical symptoms of anatomical diagnosis. I think this book is a worthwhile addition to the library of both the medical student and the practicing physician.

Pacita M. Estrella, M.D.

NEWS of the STATE

Pediatric Institute Opens Doors

The recently completed Illinois State Pediatric Institute for Mentally Retarded Children, Chicago, received its first 40 patients, transferred from Lincoln and Dixon State schools, in October. They were transferred from existing institutions because they have completed initial shots, x-rays, and other medical examinations, enabling the institute's presently small staff to give them immediate care.

Designed for care, treatment, training, and research, the facilities will be limited to care during the first phase; as a qualified research and training staff is gained the other areas will be included.

Its seven stories will house 585 crib-beds for resident care of mentally retarded children under six years of age. The main floor will serve as an outpatient department with parent counselling facilities, administrative and food service areas, and an auditorium.

Each upper floor has been divided into an east wing for patient wards and supporting services; a central area for semi-circular visitors' lounges, medical services, and special children's research areas; and a west wing for specialized services. The latter are nurse training facilities, second floor; recreational and educational therapy, third floor; physiotherapy, fourth floor; infirmary, fifth floor; psychological testing and research, pharmacy, and laboratory, sixth floor.

Patient wings on each floor have three 32-bed sections divided into 16-bed units and further subdivided by partitions into eight-bed units.

A roof terrace will be a sheltered play area for the children.

The red brick and limestone building is adjacent to the Illinois State Psychiatric Institute, with both sharing major laboratories, surgical suites, and x-ray departments.

Dr. Lester H. Rudy, superintendent of the Psychiatric Institute, has been named acting director of the Pediatric Institute.

The Institute is intended to relieve the present large waiting lists for admissions — as of September there were 716 children in Illinois up to age six on waiting lists at Lincoln and Dixon — and reduce overcrowded conditions in existing institutions.

New Headquarters Building for ACS

Ground was broken in October for the $3 million eight-story American College of Surgeons' Chicago headquarters at 55 E. Erie St. on the southwest corner of Rush and Erie.



SKETCH of new headquarters of the American College of Surgeons.

Ceremonies were part of the annual meeting program.

The 75,000 foot square structure, scheduled for occupancy in May of 1963, will replace the present offices in four buildings at 40 E. Erie St. The college hopes to preserve the mansion, largest of the four, but the remaining ones will be razed.

There will be floors for meetings, a lunchroom, library, exhibit and reception areas, editorial offices for its publications, a business department and assembly, the executive staff offices, and space for fellowship and professional services. One floor and a portion of another will be set aside for expansion.

Present at the ceremonies were Dr. Loyal

Davis, Chicago, chairman of the board of regents of the college; Dr. I. S. Ravdin, Philadelphia, president; and Dr. Robert M. Zollinger, Columbus, O., incoming president.

Children's Hospital Replaced at U. of C.

A 100-bed children's hospital exclusively for bed-patients will be built at the University of Chicago, replacing the 60-bed Bobs Roberts Memorial Hospital for Children and the 34-bed Home for Destitute Crippled Children. As yet it has no name. Completion is scheduled for 1963 at an estimated cost of $2 to $2.5 million.

The site will be north of Lying-In Hospital, near Drexel Avenue between 59th and 58th streets at the west end of the medical center.

Building plans were consolidated in an agreement between the Home and the university wherein the latter will build the hospital and lease it to the Home for ninety-nine years at $1 a year. The Home's endowment funds will be for hospitalization of some of the children.

The new hospital will bring together all inpatient children's facilities.

Surgeons Receive Illinois Fellows

Fifty-three Illinois surgeons were inducted as Fellows of the American College of Surgeons during the annual Clinical Congress in Chicago in October. The physicians from Chicago are: James M. Allison, Jr., Robert J. Baker, Warren A. Clohisy, Matthew J. Bulfin, William J. Cahill, Beulah Cushman, John T. Grayhack, B. Herold Griffith, Harold A. Kaminetzky, and William T. Kerhahan, Jr. Also from Chicago are Drs. William W. Klatchko, Andreas G. Kodros, Ernest G. Nora, Jr., Paul F. Nora, Stanley J. Opalinski, Harry M. Richter, Jr., Donald Rolnick, Jerome M. Silver, Charles J. Staley, Thomas E. Starzl, Otto H. Trippel, and James B. Williams.

Physicians from other areas are: John W. Brouhard and George F. Smith, Arlington Heights; Robert R. Harriage and Otto L. Siewert, Aurora; Frank J. Jirka, Jr., Berwyn; Murray R. Gordon, Blue Island; George E. Fagan and J. Robert Swain, Champaign; and Charles D. Collins, Chicago Heights.

Others are: Alan M. Taylor, Danville; George C. Moran, Downers Grove; Robert M. McCray, Elmhurst; E. Seymour Burge, John B. Graham,

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Also Donald H. Dexter and Kenneth T. Pawlias, Macomb; Eugene Tsai, Oak Lawn; Gordon H. Sprague, Paris; James A. Calams, Park Ridge; Robert W. Brandes, John W. Otten, and Roy E. Vandenberg, Peoria; George R. Farrell, Rockford; Theodore Grevas, Rock Island; and Patrick B. McVary, Springfield.

ISMS Hosts a Party for Dr. Yoder

Dr. Franklin D. Yoder, Wilmette, recently appointed director of the Illinois Department of Public Health, was feted by the Illinois State Medical Society, which had supported him for the position, with a reception and dinner in his honor at the Leland Hotel, Springfield, October 7. Dr. Edwin S. Hamilton, Kankakee, president of the Society, presided. Special place mats bearing Dr. Yoder's picture and the names of his staff were used.

About 50 attended, including Gov. Otto Kerner, members of Dr. Yoder's staff, and officers and councilors of the Society. Also present were Robert L. Richards, executive administrator; Mrs. Frances C. Zimmer, executive assistant; and staff directors Albert G. Boeck, Roger N. White, Donald L. Martin, and Walter L. Oblinger. Charles Johnson, field services representative of the American Medical Association, also attended.

Dr. Yoder was the luncheon speaker at the hotel on October 8, following the Society's annual Secretaries Conference which drew county medical society officials from all parts of the state. He spoke on "Private Medicine and Public Health." Dr. Edward A. Piszczek, Chicago, Council chairman, officiated at the luncheon.

Dr. Jacob E. Reisch, Springfield, secretary-treasurer, opened the morning session, and Dr. Eugene F. Moore, Collinsville, presided. Administrative matters were discussed, and Dr. Hamilton, the principal speaker, reported on the Illinois implementation of recently enacted legislation to provide medical care for needy and near needy people 65 or over.

Other physician speakers were H. Close

(continued on page 53)



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State News *(continued from page 50)*

Hesseltine, immediate past president, and Noel Shaw, Chicago; Clarence G. Glenn, Decatur; James A. Stocker, Springfield; Lewis W. Tanner, Danville; Sidney J. Kaplan, Waukegan; Robert L. Tucker, Pekin; Richard Cooper, Quincy; and Burtis E. Montgomery, Harrisburg.

Mental Health Clinics Set

The locations of four community-centered mental health clinics have been announced. They will be constructed at Rockford in Zone 1, Peoria in Zone 4, and Springfield in Zone 5. In Zone 6, Decatur will be the headquarters with adult facilities. Special facilities for children will be constructed at Champaign-Urbana, also in Zone 6.

The Illinois Department of Mental Health previously announced that two clinics will be constructed in the Chicago metropolitan area, which includes Zones 2 and 3.

Population, geographic location, hospitals, university and other existing facilities, and availability of professional personnel were factors in making the final selections.

Surveys of hospitals by the Joint Committee of Accreditation of Hospitals, the Council of Medical Education and Hospitals of the American Medical Association, and the Joint Information Service of the American Psychiatric Association and National Association for Mental Health played a major part in relocation.

Each clinic will have about 160 beds for adults with mental illnesses, 20 beds for the treatment of alcoholics, plus a large and well-developed outpatient center for alcoholics, and 20 beds designed for geriatrics, and a minimum of 20 beds for treatment of emotionally disturbed children. There are no plans to include beds for the general treatment of children. Construction is expected to cost $25,000 a bed.

New mental hospitals are already being constructed at Harrisburg and Centralia. The clinics at Rockford, Peoria, and Springfield, and the two in the metropolitan area will cost an estimated $7.96 million each. The adult facilities to be constructed at Decatur will cost about $6 million, while the children's facilities at Champaign-Urbana will cost $1.96 million.

(continued on page 54)

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Illinois Pathologists Choose Officers

The Illinois Society of Pathologists recently selected these physicians as its new officers: Harold Grimm, president; Grant C. Johnson, first vice-president; James B. Hartney, second vice-president; J. Robert Thompson, secretary-treasurer.

Catholic Physicians Found Guild

A group of Roman Catholic physicians have formed the Catholic Physicians Guild of Chicago to seek spiritual improvement and resolve moral problems in their practices. Dr. George C. Blaha, medical director of Cook County Hospital, is interim president.

The Guild has the approval of Albert Cardinal Meyer, archbishop of Chicago, according to a spokesman, and is seeking members from the approximately 2,000 Catholic physicians and surgeons of the Chicago archdiocese to augment its present membership of 100.

Its objectives are "spiritual improvement of the member," "application of God's law to the practice of medicine," "communication to the public of the Catholic doctor's image," "to speak with truth and unity for Catholic physicians on matters involving the teaching of the church," and "to resolve with authority and clarity moral-medico problems."

Meetings will be semi-annual, and an annual "White Mass" in Holy Name Cathedral will be sponsored.

Appointments

Robert K. Crane, Ph.D., internationally recognized biochemist, has been appointed professor of biochemistry and chairman of the department at the Chicago Medical School effective Jan. 1, 1962.

He is a specialist in intermediary carbohydrate metabolism and has recently been concerned particularly with the absorption of carbohydrates from the intestinal tract as part of the mechanism by which sugar is utilized by the body.

Dr. Crane will head the department's greatly expanded research facilities in the new Institute for Medical Research. He has been on the faculty of the Washington University Medical School, St. Louis, since 1950.

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(continued from page 54)

The appointment of Dr. Walter Koch, an authority on environmental physiology, as full-time associate professor of public health has been announced by the Chicago Medical School.

Dr. Koch holds M.D. and Ph.D. degrees from the University of Vienna and was on the faculty of the Hebrew University School of Medicine in Jerusalem for 20 years before coming to America three years ago.

Prior to his appointment he was medical research supervisor for studies on heat physiology at the research laboratory of the American Society of Heating, Rerfrigerating and Air-Conditioning Engineers in Cleveland.

Leads Project on Mental Retardation

Paul Kliger, formerly of the Peoria Mental Health Society, has been appointed director of the Project on Mental Retardation of the Illinois Council for Mentally Retarded Children. Through a Wieboldt Foundation grant the Project will undertake the improvement and coordination of existing services and the establishment of new services in Greater Chicago. It is co-sponsored by the Council, the Welfare Council of Metropolitan Chicago, and the Mental Health Society of Greater Chicago, which will assume the administrative direction.

Physician Diplomats

The American Medical Association's Department of International Health is seeking the names of physicians who will volunteer to serve in the mission field on a temporary basis. It is receiving the cooperation of agencies representing every religious denomination in the U. S. that sponsors medical missionaries.

The first member of the group of five volunteer physicians from Tulsa's First Presbyterian Church flew to Miraj, India, in mid-August for a six-week service in the medical center there. He returned at the end of September, and the next doctor made the trip. In all, the five physicians will donate a total of thirty weeks to the program, which is endorsed by the Tulsa County Medical Society. Funds for medical equipment, transportation, and other expenses were raised through church and public contributions.

Physicians interested in volunteering for such

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(continued from page 56)
service are asked to write directly to the AMA Department of International Health, 535 N. Dearborn St., Chicago 10.

Awards

Dr. Edward Press, Evanston, won the gold medal Grulee Award for the performance of outstanding service at the annual meeting of the American Academy of Pediatrics in Chicago. Dr. Press was chairman of Chicago's poison control center, the first that led to the creation of 420 centers throughout the nation. He is health director of Evanston and is a former field director of the American Public Health Association.

Dr. Clement A. Smith, Boston, received the Borden Award for outstanding achievement in research relating to infant feeding. Dr. Smith, who received $1,000 and a gold medal, is the newly named editor of *Pediatrics*.

Also, the winners of the E. Mead Johnson Awards for outstanding research in child health were Dr. Lytt I. Gardner, department of pediatrics, State University of New York Upstate Medical Center, Syracuse; and Dr. Donald E. Pickering, University of Oregon Medical School, Portland. Each received $3,000 and a sheepskin scroll.

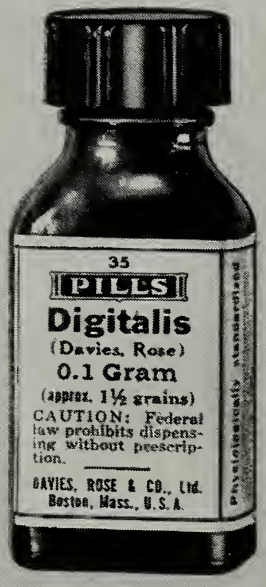
The winners of the Frederick Rawson, Jr. scholarships for outstanding sophomore students in medicine at Northwestern University Medical School were Susan Anderson, Marysville, O., and John Dunn, Elgin. The $500 awards, established in memory of Frederick H. Rawson, Jr., a graduate of Northwestern, are given for high standing as a student and devotion to the field of medicine.

Michael V. Herman, Westville, Ill., a senior, received the George J. Dennis Phi Rho Sigma award of a $100 bond for maintaining the highest scholastic average during the first three years of medical school and another Phi Rho Sigma award of a $50 bond for the person who contributed most toward his fraternity's winning a certificate of recognition for the highest scholastic average during the preceding year.

Michael B. Lewis, Chicago, a sophomore,
(continued on page 61)

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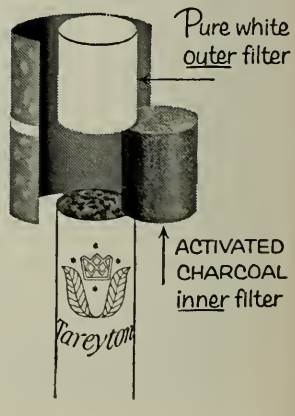
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took the $100 Sigmund S. Winton award to the student who has done the best work in the field of biochemistry during his freshman academic year. He also received Phi Beta Pi's $50 Leslie B. Arey award for oustanding scholastic achievement in the study of anatomy.

Election

The 1962 officers of the Metropolitan Chicago Chapter of the American College of Surgeons are Drs. Louis P. River, president; Robert J. Freeark, vice-president; and John B. Condon, secretary-treasurer. Councilors are Drs. John J. Fahey, Charles B. Puestow, and William J. Gillesby.

Mental Health Commissioners Appointed

Illinois' first Board of Mental Health Commissioners is composed of seven members with terms ranging from two to five years. It replaces the Board of Public Welfare Commissioners.

Appointments and expiration of terms are as follows:

John Zvetina, Cicero, a practicing attorney, secretary of the Illinois Board of Public Welfare Commissioners, professor of law and chairman of the business law department at Loyola University; January, 1963.

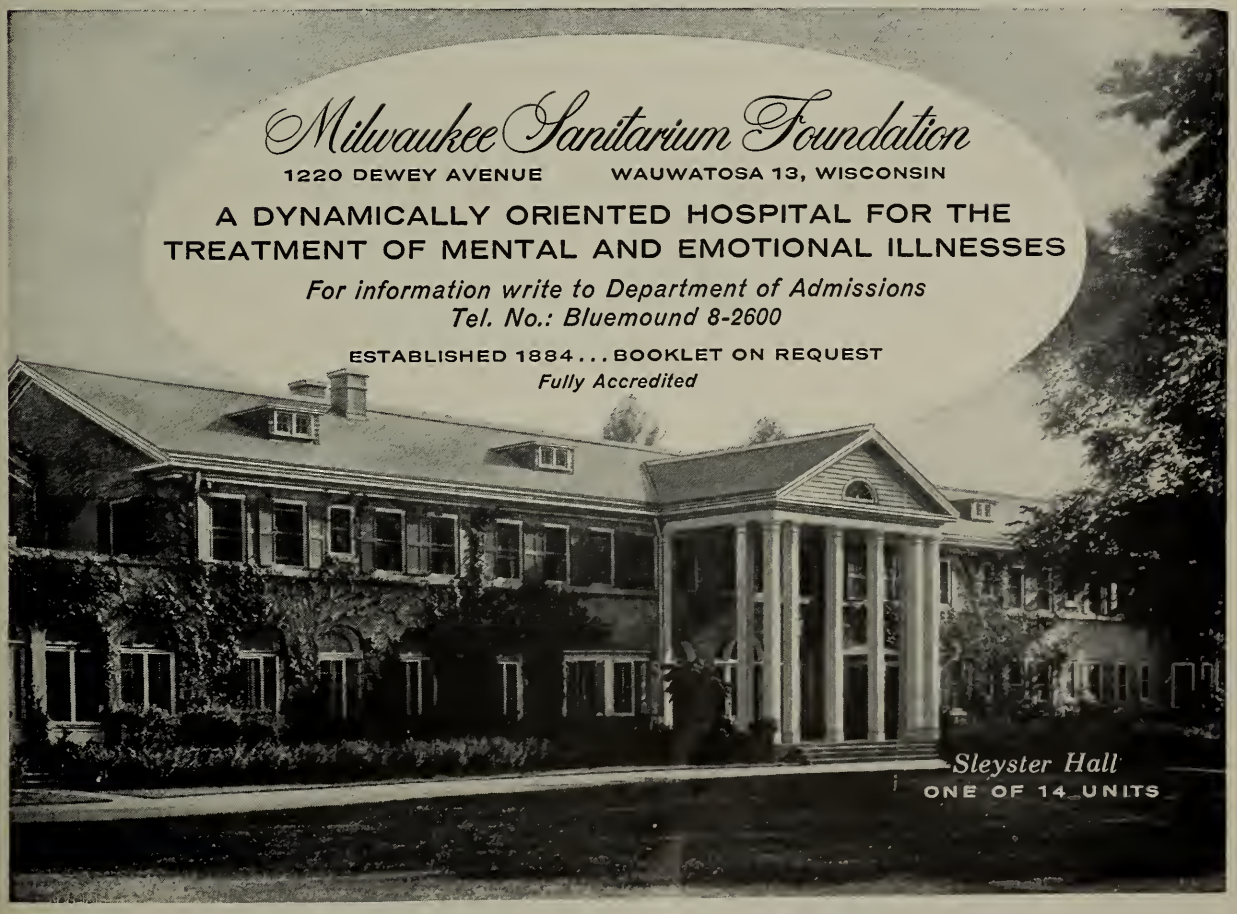
Rabbi Ralph Simon of Congregation Rodfei Zedek, Chicago, vice-chairman of Illinois Board of Public Welfare Commissioners, member of the board of directors, Jewish Federation of Chicago; January, 1964.

Curtis Small, a newspaper publisher at Harrisburg; January, 1965.

Dr. Emmet F. Pearson, Lake Springfield, physician and chief medical consultant of the Illinois Division of Vocational Rehabilitation and a member of the board of directors of Child and Family Services and United Community Services, Springfield; January, 1966.

Mrs. James Holland, Rockford, president of Family Consultation Service, vice-president of Mental Health Society of Winnebago County,

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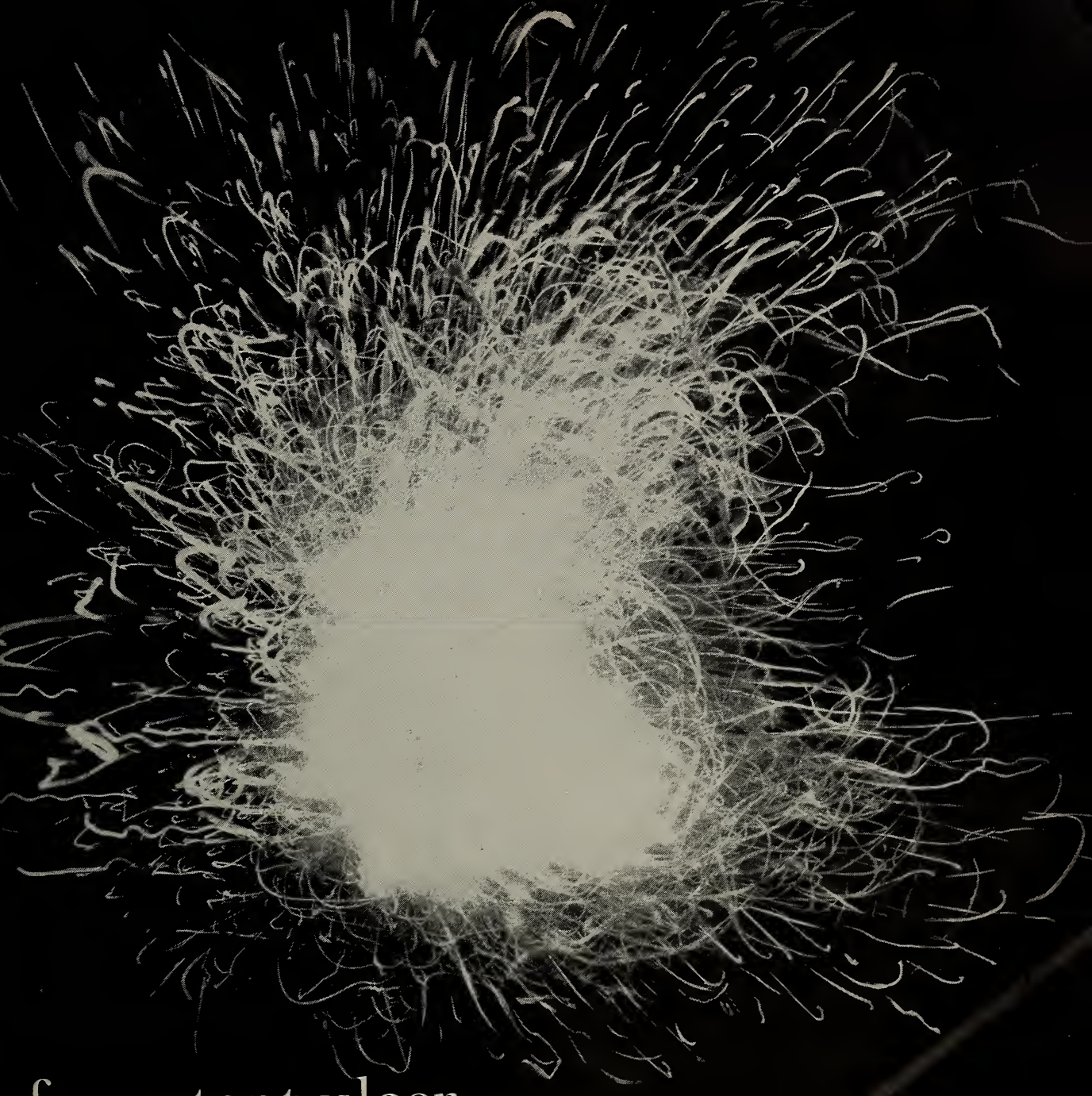


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and a board member of the Illinois Association of Mental Health; January, 1967.

Willard King, Chicago, attorney and governor of the Menninger Foundation, trustee of the Museum of Science and Industry and the Chicago Historical Society; January, 1968.

Alex Elson, Chicago, attorney, lecturer at Yale Law School, an arbitrator in labor-management disputes since 1945, vice-chairman of the American Civil Liberties Union, and chairman of the civic committee on Mental Health Information; January, 1968.

Deaths

Charles K. Barclay, Joliet, a graduate of the Rush Medical College in 1904, died May 21, aged 81.

Clyde G. Blake, Peoria, a graduate of Northwestern University Medical School in 1926, died June 1, aged 64.

William S. Bougher*, retired, a graduate of Jenner Medical College in 1908, died September 5, aged 94. An emeritus member of the Illinois State Medical Society and a member of the Society's 50-Year Club and the Club's committee, he had practiced in Chicago almost 49 years before retiring five years ago. Before that he and his wife were thought to be the oldest practicing physician husband-wife team in Illinois. He was a member of Medinah Temple, past chief of its medical staff and honorary life member of Columbia Yacht Club, Chicago.

John R. Brazelton*, Jacksonville, a graduate of Northwestern University Medical School in 1943, died September 9, aged 44. He was a lieutenant colonel in the U. S. Army Reserves and was surgeon of the U. S. Army Reserves headquarters in Quincy. An officer in the Reserves since 1952, he was with the Far East Command in 1953 and was on active duty in Korea. Since 1954 he had practiced in Jacksonville.

August J. Campagna, Chicago, a graduate of the Chicago College of Medicine and Surgery in 1940, died September 28, aged 48. He was on the staff of Columbus Memorial Hospital.

John V. Fowler*, retired, Chicago, a gradu-

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ate of Rush Medical College in 1899, died September 22, aged 92. From 1918 to 1942 he was a surgeon at Norwegian-American Hospital and had practiced for 43 years in Chicago until his retirement in 1942. A member of the 50-Year Club of the Illinois State Medical Society and an emeritus member of the Society, he was president of the Chicago Medical Society in 1919. From 1909 to 1918 he was professor of clinical surgery at the Chicago College of Medicine and Surgery and also was a staff member at Lutheran Deaconess Hospital.

He is survived by two physician sons in Chicago, John V. and Frank H., who also was president of the Chicago Medical Society in 1954-55.

Samuel H. Grove*, Elmhurst, a graduate of Bennett Medical College in 1912, died February 16, aged 87.

Emory L. Hess, Anna, a graduate of Northwestern University Medical School in 1909, died April 24, aged 75.

Perry E. Ingalls, Chicago, a graduate of the Chicago College of Medicine and Surgery in 1909, died May 12, aged 77.

Michael J. Lavin*, Pontiac, a graduate of the University of Illinois College of Medicine in 1942, died September 12, aged 44. During World War II he was a lieutenant in the Navy Medical Corps.

Alger V. Lindberg*, Crystal Lake, a graduate of the Loyola University School of Medicine in 1922, died September 23, aged 65. A former chief of staff at Sherman Hospital, Elgin, he also was a former health officer in Crystal Lake, a member of its Board of Education, and had practiced there 38 years.

Ansel O. Magill*, retired, Decatur, a graduate of Bennett Medical College in 1913, died August 31, aged 79. Until his retirement in 1947 he had practiced in Decatur for 27 years. A past president of the Macon County Medical Society, he received the Silver Beaver from the Boy Scouts in 1944, their highest honor for citizens active in the movement. He did postgraduate work at Chicago's Institute of Surgery.

Patrick H. McNulty*, Chicago, president of the Chicago Medical Society since last June, died November 2, aged 62. For a number of years he had served that society as its delegate to the Illinois State Medical Society. Dr. Mc-

(continued on page 67)

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Nulty was a graduate of Loyola University School of Medicine in 1924 and did postgraduate studies at the University of Vienna and Cook County Hospital. In 1938 he was certified in urology.

At the time of his death he was head of the urology department at Little Company of Mary Hospital in Evergreen Park, where he had been a staff member 30 years. In addition, he was a consulting urologist at South Shore, Holy Cross, St. Bernards, and Roseland Community hospitals.

In 1957 Dr. McNulty was chairman of the ISMS committee on arrangements for the annual meeting and the following year became second vice president of the Society. A member of both the Chicago Urology Society and the American Urological Association, he was assistant professor of urology at Loyola and an associate in urology at Cook County Hospital from 1934 to 1942.

John G. Meyer*, Springfield, a graduate of the Hahnemann Medical College, Chicago, in 1911, died September 7, aged 78. He was an emeritus member of the Illinois State Medical Society and a member of its 50-Year Club.

Stanley J. Norys*, Crystal Lake, a graduate of the Chicago Medical School in 1922, died September 26, aged 64. For the past 39 years he was a staff member at Henrotin Hospital and also was on the staff at St. Joseph's Hospital, Elgin.

Charles A. Roberts*, Rockford, a graduate of the Chicago College of Medicine and Surgery in 1909, died September 13, aged 77. A former president of the Winnebago Medical Society, he had practiced in Rockford 30 years and was president emeritus of the medical staff at Swedish-American Hospital there and served on the Rockford Selective Service Board.

Emma H. Salisbury*, Carthage, a graduate of the Keokuk Medical College of Physicians and Surgeons in 1903, died June 13, aged 84. She was an emeritus member of the Illinois State Medical Society and belonged to the 50-Year Club.

Norbert F. Sandomier*, Chicago, a graduate of the Chicago College of Medicine and Surgery in 1916, died September 6, aged 70. A staff member of Chicago State Hospital for the past 10 years, he had practiced in Chicago over 40 years.

Alvin M. Stober*, retired, Waukegan, a graduate of the University of Illinois College of Medicine in 1901, died September 18, aged 82. He was a member of the 50-Year Club of the Illinois State Medical Society and also was an emeritus member of the Society. At one time he had taught at the Chicago Medical College and had practiced in Chicago for many years before retiring 13 years ago.

Willard Van Hazel*, Chicago, a graduate of the Rush Medical College in 1925, died August 24, aged 65. He joined the staff of St. Luke's Hospital in 1929, later becoming senior attending thoracic surgeon. He was clinical professor of surgery at the University of Illinois College of Medicine, where he had been on the faculty since 1929, and attending surgeon-in-charge of thoracic surgery at the university's Research and Education Hospital. He was a fellow and member of the founders' group of the American College of Surgeons, a past president of the Chicago Tuberculosis Society, and a member of the American Association of Thoracic Surgery. He was certified in thoracic surgery in 1939.

Max A. Weisskopf*, Berwyn, a graduate of the Rush Medical College in 1896, died August 19, aged 87. He had practiced in Chicago's West Side and Berwyn for 65 years. During his association with St. Anthony de Padua Hospital, he was a staff member, president of the staff, chairman of the department of obstetrics, and consultant in obstetrics. He was a fellow in obstetrics of the American College of Surgeons and a member of the 50-Year Club of the Illinois State Medical Society. In World War I he was a captain in the Army Medical Corps.

Arvid E. Westerdahl*, Elmhurst, a graduate of Rush Medical College in 1933, died September 6, aged 65. He was a staff member at West Suburban Hospital and practiced for 26 years in Oak Park.

Dellie L. Wilhoit*, Martinsville, a graduate of the Kentucky School of Medicine, Louisville, in 1896, died August 25, aged 92. Martinsville had been his place of practice for 65 years.

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FOR SALE: Long-established industrial surgery practice. Southeast side of Chicago. May be had for equipment cost. Write box 343, c/o Ill. Medical Journal, 360 N. Michigan Ave., Chicago 1, Ill.

PARTNER WANTED: Internal medicine, 70% cardiology. Three girl Chicago loop office. Fully-equipped including laboratory for simple chemistries and fluoroscope. May require combined hospital connections. Object more freedom for vacations, meetings, better planning for retirement. Write Box 344, c/o Ill. Medical Journal, 360 N. Michigan Ave., Chicago 1, Ill.

PHYSICIANS SEEKING LOCATIONS IN ILLINOIS — are notified to contact the Physician's Placement Service in the office of the Illinois State Medical Society, 360 N. Michigan Ave., Chicago 1, Illinois. A file listing communities seeking physicians is maintained. There is no charge for this service of the Society.

GENERAL PRACTITIONER WANTED: Eight man group desires associate. Up to six weeks vacation. Located two hours from Chicago in substantial farming and industrial county. Salary with percentage first year, increasing second year, then partnership. Please reply to Box 345, c/o Ill. Medical Journal, 360 N. Michigan Ave., Chicago 1, Ill.

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Address
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THE NORBURY HOSPITAL, Jacksonville, Illinois

Abstract of Council Actions

Meeting of November 19, 1961



▶ APPROVE RESOLUTIONS FOR SUBMISSION TO AMA HOUSE OF DELEGATES

The Council approved a resolution to be submitted to the AMA House of Delegates in Denver which calls for giving veteran benefits to women surgeons who served in the Army in World War I. They performed the services of male surgeons but were not eligible for commissions or for benefits.

Also approved for submittal to the AMA House was a resolution by the Adams County society urging the formation of clubs at junior and senior high school levels for boys and girls interested in becoming physicians. The resolution also proposed the establishment of a national revolving loan fund to help students to complete a medical education, and of a fund to supplement the salaries of men in teaching in medical schools.

▶ CONTRIBUTIONS TO IMPAC FOR POLITICAL EDUCATION URGED

The Executive Committee recommended that membership of ISMS be urged to contribute $2 each to the Illinois Medical Political Action Committee to finance the cost of political education projects for 1962. None of this money is to be used to support a candidate or party. Council concurred.

▶ RE-INVESTMENT OF RESERVE FUNDS BEING CONSIDERED

Dr. Burtis E. Montgomery, Harrisburg, chairman of the Finance Committee, recommended plans for the re-investment of reserve funds of the Society in order to give a larger return than is presently being received. The investments will be made with the advice of the Continental Illinois National Bank and Trust Company. The Council approved the recommended program.

▶ PROCESSING OF RELATIVE VALUE STUDY RETURNS STARTED

Processing of the Relative Value Study questionnaire has begun, Dr. C. Elliott Bell, Decatur, chairman of the Committee on Relative Value, reported. A report of the results, based on 3,450 adequate returns, is expected to be available by the third week in December. Formal hearings, at which specialty groups and general practitioners will be heard, will be held January 13 and 14. These hearings will be for the purpose of developing additional information. The final report is expected to be mailed about February 15 to the House of Delegates and will include about 1,500 to 2,000 unit values.

▶ RADIATION NOT AT HAZARDOUS LEVEL, DR. YODER REPORTS

Fallout and other radiation have not reached a hazardous level, Dr. Franklin D. Yoder, director of public health, reported. It is hoped that physicians will assure their patients to that effect. The state is watching the situation carefully, particularly with respect to iodine, cesium, and strontium.

Dr. Yoder also indicated that the department of public health is searching for a qualified medical officer to head its civil defense health medical services. Assistance from the ISMS members will be appreciated in this recruitment.

▶ CARE OF STROKE PATIENT PROGRAM PROGRESSING SATISFACTORILY

Dr. Edward W. Cannady, East St. Louis, chairman of the Committee on Aging, reported that the committee's program for care of the stroke patient was progressing very satisfactorily. Over 300 persons attended morning and afternoon demonstrations in East St. Louis and Bellville, Sept. 7, and about 90 physicians attended an evening session. Similar programs were scheduled for Mattoon on Nov. 30 and for Springfield on Dec. 7.

PRESENT PROGRAM FOR DISASTER MEDICAL CARE

Dr. Max Klinghoffer, Elmhurst, chairman of the Committee on Disaster Medical Care, presented a 13-point program for the coming year, approved by the Council:

(1) Training all physicians in disaster medical care, regardless of specialty; (2) offering by physcians of disaster medical care courses for civilians; (3) orienting physicians in the civil defense emergency hospital; (4) training physicians in basic radiation physics; (5) using the talents of physicians with war or disaster medical care experience; (6) bringing about a closer rapport with allied professions; (7) developing a joint project in this field with the Illinois Hospital Association; (8) training in water supply problems and sanitation; (9) supporting USPHS in the implementation of a "Self Help" training program; (10) providing more information in medical journals; (11) having wider discussion at hospital staff meetings; (12) developing liaison with labor groups and industry; (13) indoctrinating physicians in basic concepts of communication, electric power, and other services.

A prototype disaster medical care manual was approved for state-wide distribution.

CHANGES IN ANNUAL MEETING PROGRAM DISCUSSED

Dr. Lorne Mason, Evanston, chairman of the Annual Meeting Program Committee, reported that the committee considered various suggestions for increasing attendance at the annual meeting, the most important considerations being changes in the meeting time, location, and type of program.

Following a discussion, the Council decided that there would be no change in the date for the meeting—usually around the third or fourth week in May. It was pointed out that hotel arrangments must be made several years in advance. Accordingly, the staff was directed to look into available hotel accommodations for 1963-4-5. The committee was authorized to develop the type of program it deems to be the most attractive for Sunday, May 13 through Thursday, May 17, 1962.

APPROVE HOSPITAL-NURSING HOME AFFILIATION IN PRINCIPLE

The Council approved in principle the voluntary affiliation of a hospital and nursing home under an integrated plan to improve the quality and economy of a community's over-all medical care.

It is proposed that the minimal standards for affiliating nursing homes should include, at least, licensure by the state and listing by the American Hospital Association, or other equally satisfactory qualifications. Physicians should have the primary responsibility for admission, transfer, and discharge of patients as well as providing medical care. Final plans are to be submitted to the Council at a later date.

COUNCIL VOTES CONFIDENCE IN IMPARTIAL MEDICAL TESTIMONY PROGRAM

The Council gave a vote of confidence to the Impartial Medical Testimony Committee. The plan has been in effect in the Federal Courts of Chicago for the last two years, and now has gone into operation in the Circuit and Superior Courts.

LARGE CORPORATIONS ADOPT MEDICAL CARE PROGRAMS FOR EMPLOYEES

Dr. Maurice M. Hoeltgen, Chicago, chairman of the Committee on Prepayment Plans and Organizations, reported that the Metropolitan Life Insurance Company had announced it will carry a medical care insurance program for employees of General Motors in Illinois, effective Jan. 1.

Aetna Insurance Company is to develop a program for Chrysler, and the John Hancock Company for Ford. Cook, Lake, and Vermilion Counties are involved primarily. Further information and details will be provided as these programs are developed.

Volume 120, No. 6 December, 1961

The ILLINOIS Medical Journal

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Published monthly by the Illinois State Medical Society, 360 N. Michigan Avenue, Chicago 1, Ill. Subscription $5.00 per year, in advance, postage prepaid, for the United States, Cuba, Puerto Rico, Philippine Islands, and Mexico. $7.00 per year for all foreign countries included in the postal union. Canada, $5.50. Single current copies 75 cents.

Second class postage paid at Chicago, Illinois. POSTMASTER: Send notices on form No. 3579 to Illinois State Medical Society, 360 N. Michigan Ave., Chicago 1, Ill.

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treatment
for surgical
infections

CHLOROMYCETIN®

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Wound infection—a common postoperative complication—can very often be traced to staphylococcal invasion.[1-3] In such cases, CHLOROMYCETIN may well be an agent of choice, since "...the very great majority of the so-called resistant staphylococci are susceptible to its action."[4]

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See package insert for details of administration and dosage.

Warning: Serious and even fatal blood dyscrasias (aplastic anemia, hypoplastic anemia, thrombocytopenia, granulocytopenia) are known to occur after the administration of chloramphenicol. Blood dyscrasias have occurred after both short-term and prolonged therapy with this drug. Bearing in mind the possibility that such reactions may occur, chloramphenicol should be used only for serious infections caused by organisms which are susceptible to its antibacterial effects. Chloramphenicol should not be used when other less potentially dangerous agents will be effective, or in the treatment of trivial infections such as colds, influenza, or viral infections of the throat, or as a prophylactic agent.

Precautions: It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes, such as leukopenia or granulocytopenia, before they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior to development of aplastic anemia.

References: (1) Pulaski, E. J., & Taylor, L. W.: *California Med.* 92:35, 1960. (2) Finland, M.: DM: Disease-a-Month, Sept., 1960, p. 3. (3) Monsour, V.; Bernard, H. R., & Cole, W. R.: *Missouri Med.* 57:1006, 1960. (4) Welch, H., in Welch, H., & Finland, M.: Antibiotic Therapy for Staphylococcal Diseases, New York, Medical Encyclopedia, Inc., 1959, p. 14. (5) Bauer, A. W.; Perry, D. M., & Kirby, W. M. M.: *J.A.M.A.* 173:475, 1960. (6) Petersdorf, R. G., *et al.*: *Arch. Int. Med.* 105:398, 1960. (7) Goodier, T. E. W., & Parry, W. R.: *Lancet* 1:356, 1959. (8) Lind, H. E.: *Am. J. Proetol.* 11:392, 1960.

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AS I SEE IT FROM '360'

By Robert L. Richards
Executive Administrator

THE TROUBLEMAKER

The Title "Troublemaker" may very well apply to those of us who belong to professional associations. The photograph below was provided by the Nationwide Insurance Company of Columbus, Ohio. It first appeared in a series of advertisements in three national magazines which caught my eye. Although the italics in the caption are self-explanatory and valid for all of us who seek and desire freedom of action — it may be even more applicable to the members of ISMS. Frequently I have heard members say that everything at the State Society level is "cut and dried" beforehand. (Incidentally, the quote is from a letter received the day I wrote this article). To the quotation I must reply "false," because it simply "ain't true" from what I have seen of the actions of the committees, the Council, and the House of Delegates.

It would be more than helpful if members would not be silent. When issues are at stake, especially does the Society need comments, ideas, and understanding. Day-by-day reading of materials mailed from the State Society will keep all informed on the problems before the committees and the Council. Week-by-week interest in county medical societies will result in well informed members who can stimulate interest in the State Society and the American Medical Association affairs. Year-by-year attention to the art of constructive criticism will bring to us the lasting satisfaction that we are not troublemakers. The next time you see something about ISMS that needs correction, don't be silent. You may be the very person who can help most in solving difficult problems.



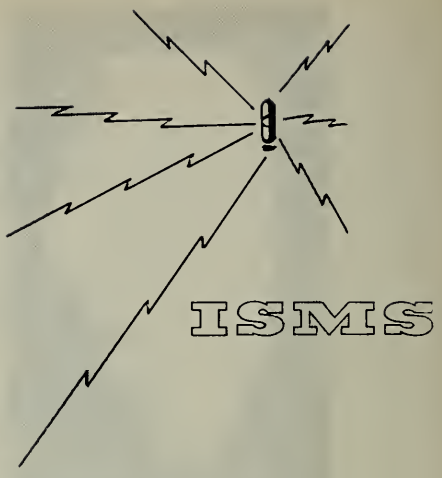
Troublemaker. *He is the silent one.* He never speaks up on issues. He never sounds off in the letter column of his local newspaper. He never writes his Congressman. He is quiet as a clam. How could Democracy succeed . . . if all of us, like this one, withheld our opinions, our ideas, our criticisms? Active, day-by-day participation in government, in society, in business associations is a responsibility for each and every one of us. The *silent* troublemaker fails to understand this. He never dares to question an oppressive law. In his wish to offend nobody, he offends Democracy. *For Democracy begins at home.*

Quoted from an ad of Nationwide Mutual Insurance Co., Columbus, Ohio



He carries with him the essence of our company . . . our philosophy, our products, the results of our technical skills and research findings. He can and will provide you with anything you wish to know about us; about our products—what they will do—and what they will *not* do. He will provide you with samples for your own clinical evaluations, or with reports of other physicians' findings should you wish them. He is dedicated to helping you keep abreast of the newest and best in pharmaceuticals.

In the next month or two, he will be detailing Colrex Compound and Ro-Cillin. If you cannot wait, write: **ROWELL LABORATORIES, INC., BAUDETTE, MINN.**



Announcements

Biomedical Seminars

Northwestern University Medical School has begun a new monthly series of Biomedical Seminars open to all interested persons free of charge at 4 p.m. in Room 541 of the Ward Memorial Building.

The schedule for the next two months follows:

Thursday, January 18: Seymour Ehrenpreis, associate professor of pharmacology, Georgetown University School of Medicine, "Reactions of Drugs with Macromolecules."

Thursday, February 8: Dr. H. Stanley Bennett, professor of anatomy and dean, Division of Biological Sciences, University of Chicago, "The Impact of Electron Microscopy on Concepts of Cell Structure and Function."

The series opened in December with a talk on "Medical Education: Art or Science?" by Dr. George E. Miller, professor of medicine and director of research in medical education, University of Illinois College of Medicine.

For further information call J. B. Kahn, Jr., associate professor of pharmacology, at SU 7-4500, ext. 259 or 267.

PG Courses

The American College of Physicians will present the fifth and sixth in a series of eight postgraduate courses January 15-18 and January 29 through February 1. The fifth course, "Internal Medicine — Today's Problems in Diagnosis and Management, and Tomorrow's Projections," will take place in Ochsner Foundation Hospital, New Orleans, with Drs. Seldon Mann and William D. Davis, Jr., as co-directors.

The sixth course, "Medical Genetics," at the University of Michigan Medical School, Ann Arbor, has Dr. James V. Neel as director.

The fee for ACP members is $60; for nonmembers $80. Full details may be obtained from the Executive Offices of the College, 4200 Pine St., Philadelphia 4.

1962 Growth of Medicine Series

Northwestern University Medical School's 1962 Growth of Medicine Series will be on Tuesdays from 8:00 to 9:00 a.m. in the Ward Memorial Building. The first half of the series follows:

January 9: Dr. John H. Talbott, editor, Journal of the American Medical Association, "The Meaning of Medical History."

January 16: Dr. Frederick Stenn, assistant professor of medicine, Northwestern University Medical School, "Prehistoric and Primitive Medicine."

January 23: Dr. Stenn, "Egyptian Medicine."

January 30: A. Leo Oppenheim, Ph.D., professor, Assyriology department, Oriental Institute, University of Chicago, "Babylonian Medicine."

February 6: Dr. Samuel Zakon, professor of dermatology, Northwestern University Medical School, "Hebrew, Arabic, Persian, and Indian Medicine."

February 13: Leslie Arey, Ph.D., professor of

(continued on page 21)

anatomy, emeritus, Northwestern University Medical School, "Greek and Roman Medicine."

The final four lectures will be noted in a future JOURNAL.

Course in Radiation Physics

The annual Northwestern University Medical School course in Radiation Physics will again be open to all interested physicians. The course is scheduled for Monday evenings 6:45 to 9:00 p.m. January 8 through May 28, 1962, at Chicago's Veterans Administration Research Hospital.

Residents must pay a $25 tuition fee and practicing physicians a $50 one. To apply write the Registrar at Northwestern, 303 E. Chicago Ave., Chicago 11.

N.U. Seeks More Top Students

Northwestern University will again accept 25 talented high school seniors for the 1962-63 academic year of its accelerated six-year medical training program initiated last fall.

Interested students are urged to submit preliminary applications before year's end directly to C. W. Reiley, director of admissions, Evanston. The university prefers that potential applicants take College Board tests in December and January, rather than in March.

Final applications and special additional forms must reach the admissions office no later than March 1, 1962.

PG Course: Clinical Rheumatology

The Mayo Clinic and the Mayo Foundation are presenting a postgraduate course on "Clinical Rheumatology" Jan. 22-24, 1962, in Mann Hall in the Medical Sciences Building, Rochester, Minn.

The American Academy of General Practice and the Canadian College of General Practice will give credit to members attending this course.

The fee is $5 for registration and $55 for the course. The number of physicians who can be accommodated is limited. Those wishing to attend should communicate with M. G. Brataas, secretary, Postgraduate Courses, Mayo Clinic-Mayo Foundation, Rochester, Minn.

Jottings

The annual session of the International Medical Assembly of Southwest Texas will be held in San Antonio, Texas, Jan. 29-31, 1962, at the Granada Hotel. Those desiring further information should write Dr. Lawrence B. Reppert, president, or Mr. S. E. Cockrell, Jr., executive secretary, 202 W. French Pl., San Antonio 12.

Inter-American Conference on Congenital Defects

The National Foundation and the University of Southern California are sponsoring the first Inter-American Conference on Congenital Defects with participants from the U.S., Canada, and Mexico at the Statler Hotel in Los Angeles, January 22-24, 1962.

Dr. Norman H. Topping, president of USC, will be general chairman of the program, which will cover genetic defects, structural defects, and the clinical manifestations of each.

For details write Stanley E. Henwood, Executive Secretary, International Medical Congress, Ltd., 120 Broadway, New York 5.

Medicine on Postage Stamps

Recent issues of postage stamps of medical interest include the following:

Canal Zone—A four-value set commemorating the fiftieth anniversary of the Lions Club includes a picture of the Children's Hospital, Balboa, Canal Zone.

Cameroons—Three stamps with a surtax were issued for the benefit of the Red Cross.

Dominican Republic—The Lorraine Cross is shown on a postal tax stamp for the benefit of the Anti-tuberculosis League.

France—A 50c stamp honors the 200th anniversary of the death of Pierre Fauchard, surgeon-dentist, who gave the first account of pyorrhea alveolaris and was the first to use an orthodontal procedure for the treatment of malocclusion.

Guatemala—A four-value set honors the Red Cross.

Jugoslavia—Digitalis and eight other medicinal plants feature a nine-value set. The annual

(continued on page 22)

series of Red Cross tax and tax due stamps show two interlinked arms, symbolical of voluntary blood donation.

Philippines—A four-value set commemorates the centenary of the birth of Jose Rizal, physician and national hero.

Poland—A "Famous Pole" issue includes a stamp with a portrait of Copernicus, physician, who gained fame as an astronomer.

Sierra Leone—An independence issue includes two stamps showing Sir Milton Margai, first African physician to hail from Sierra Leone, newspaper founder, and first prime minister.

Newly Released Films

"Face of an Addict," a new motion picture on the aspects of drug addiction as they apply to medicine and associated professions, has been released by Winthrop Laboratories, Inc. In semidocumentary style it follows the career of a young physician who becomes addicted by his failure to realize the dangers of narcotics.

The film is obtainable only by physicians, nurses, medical students, pharmacists, and medical educators. It was made in Canada and produced with the cooperation of the division of narcotics control and the mental health division of Canada's Department of National Health and Welfare. Arrangements are under way for the movie to be shown in all Canadian medical schools, faculties of pharmacy schools, and some university faculties of advanced nursing.

Requests for prints should go to Winthrop's motion picture department, 1450 Broadway, New York 18.

Clinics for Crippled Children

January 3 Hinsdale, Hinsdale Sanatarium
January 4 Peoria (Cerebral Palsy), Roosevelt School
January 4 Sterling, Community General Hospital
January 5 Chicago Heights (Cardiac), St. James Hospital
January 9 East St. Louis, Christian Welfare
January 9 Peoria, Children's Hospital
January 10 Champaign-Urbana, McKinley Hospital
January 10 Joliet, Silver Cross Hospital
January 11 Cairo, Public Health Building
January 11 Flora, Clay County Hospital
January 11 Springfield, St. John's Hospital
January 16 Alton, Alton Memorial Hospital
January 16 Quincy, St. Mary's Hospital
January 17 Evergreen Park, Little Company of Mary Hospital
January 17 Elgin, Sherman Hospital
January 18 Decatur, Decatur-Macon County Hospital
January 18 Elmhurst (Cardiac), Memorial Hospital of DuPage County
January 18 Rockford, Rockford Memorial Hospital
January 19 Chicago Heights (Cardiac), St. James Hospital
January 23 Peoria, Children's Hospital
January 24 Centralia, St. Mary's Hospital
January 24 Springfield (Cerebral Palsy—All Day), Memorial Hospital
January 25 Effingham (Rheumatic Fever), St. Anthony Memorial Hospital
January 25 Mt. Vernon, Masonic Temple

New Safety Check List To Stem Home Accidents

A safety check list designed as a public service to help parents protect and educate their small children to avoid crippling home accidents has been prepared by the National Society for Crippled Children and Adults.

The Easter Seal society points out that each year between 40,000 and 50,000 children are permanently crippled in accidents and that accidents kill more children than the top seven childhood diseases combined. Most of these accidents happen at home where a child is presumed to be safest.

Titled "Is Your Child Safe?" the check list poses questions that can be answered "yes" or "no." The first 10 questions point up general home measures, while others pinpoint safety precautions in various areas of the household as well as the family automobile. Others suggest what to do if an accident should take place.

Free copies of the safety check list for parents may be obtained from the National Society for Crippled Children and Adults, 2023 W. Ogden Ave., Chicago 12.

The ILLINOIS Medical Journal

Official Journal of the Illinois State Medical Society

Volume 120, No. 6 December, 1961

SYMPOSIUM ON NEUROLOGY AND PSYCHIATRY

MODERATOR: LOUIS D. BOSHES, M.D., *Chicago*

Newer Concepts in the Management of Strokes

Medical Management of Strokes

IRVING C. SHERMAN, M.D.*

THERE HAVE BEEN many advances in our knowledge of cerebrovascular disease in recent years, the greatest progress in the area of thrombosis and encephalomalacia. Arteriography has stimulated great interest in these conditions. Study of the natural history of the disease has been intensified along with experimentation with new types of treatment.

Cerebral Blood Supply

It is important to recall that the brain receives its total blood supply from four parent cervical vessels. The paired internal carotid and vertebral arteries ultimately form the Circle of Willis, from which derive the major vessels of the brain. It is important to remember that pathology in the large cervical arteries may seriously impair brain circulation. Many abnormalities in the formation of the Circle of Willis may influence the source of blood supply to various parts of the brain.

Collateral circulation to the brain exists at several levels. There may be communication between the external and internal carotid arteries. The Circle of Willis forms a very important channel of collateral circulation. There are communications between the superficial branches of the cerebral arteries in the meninges. The variations of collateral supply from person to person make it apparent that many different phenomena may appear as the result of occlusion of any one vessel. For example, there may be no clinical symptoms from complete occlusion of one or even both carotid

Presented at the 121st Annual Meeting, Illinois State Medical Society, May 15, 1961, Sherman Hotel, Chicago

**Chicago Medical School and Michael Reese Hospital, Chicago*

arteries. Occlusion of one of the major cervical arteries may block the blood supply to only a small part of its field of irrigation; for example, when the internal carotid artery is occluded, the area of infarction may be in the field of supply or part of the supply of the middle cerebral artery. The remainder of the carotid field would be irrigated from the collateral circulation.

Site of Occlusion

A new concept of carotid system versus vertebral-basilar system disease has appeared. It is very difficult to be sure about the localization of the site of an occlusion when a certain area of brain is without blood supply. We have come to think in terms of the system that is involved. The symptoms referable to each system are distinctive and helpful in the pursuit of the specific site of pathology.

The role of extracranial causes of cerebral infarction has become increasingly important. Recent studies have shown that in some clinics as high as 25 per cent of cerebral infarcts are caused by pathologic changes in the vessels of the neck. These include intermittent kinking of vessels, pressure against osteophytes, stenosis from sclerotic placques at various points, and occlusion.

Methods of Diagnosis

In recent years a dynamic concept of strokes has evolved. Many patients have episodes of transient ischemic attacks prior to the final thrombosis and cerebral infarction. These episodes may be few or numerous, but they are often warning of trouble to come. It is during this period of warning that the greatest chance of effective therapy exists. Once occlusion has developed, the area of destruction theoretically may progress, and the condition is called a "stroke in evolution." Finally the infarction may be "complete." In the latter stages one can hope for little more than restitution by nature of those tissues damaged but not destroyed.

The newer methods of diagnosis include awareness of the significance of transient ischemic attacks and the role played by the cervical vessels. Palpation of the carotid arteries helps in making a diagnosis of carotid artery thrombosis. A bruit over the origin or bifurcation of the major vessels in the neck is suggestive of stenosis. Compression of a carotid artery with loss of consciousness and convulsive movements may indicate carotid stenosis or occlusion. Other symptoms such as dysarthria, diplopia, and paralysis of the extremities may occur in vertebral-basilar insufficiency.

Ophthalmodynamometry is helpful in diagnosing carotid artery stenosis or occlusion. Finally, with the proper indications we must resort to arteriography to demonstrate the actual site and nature of the lesion. There are a variety of methods in use, depending on what has to be demonstrated. The risks are relatively small, and the information gained may be great.

Treatment

The new concepts in treatment include anticoagulants, surgery, and rehabilitation and measures directed to include the care of the heart, lungs, and kidneys. Anticoagulants are extremely valuable in the treatment of transient ischemic attacks; they are of doubtful value in completed strokes. Thrombolytic agents are being tested but are of no proven value. Surgical procedures on the neck vessels, endarterectomy, transplant, resection, and by-pass are helpful in selected cases before complete occlusion has occurred. The proper indications are still not fully agreed upon. When a stroke is complete, we get into the field of rehabilitation where many advances have been made.

Although progress has been made, we are still left with the basic problems to be solved: The exact pathogenesis of cerebral arteriosclerosis is unknown; we cannot prevent its progress; lesions of the intracranial vessels cannot be attacked directly.

It is to be hoped that the recent wave of interest in these problems will bring forth definitive solutions.

DON'T FORGET TO MARK YOUR CALENDAR!
122nd Annual Meeting I-S-M-S
May 13-17, 1962 — Sherman House, Chicago

Surgical Treatment of Strokes

Oscar Sugar, M.D.

The commonly accepted varieties of "stroke" include: (1) hemorrhage around the brain (subarachnoid hemorrhage), (2) hemorrhage within the brain (cerebral hemorrhage), (3) ischemia due to local occlusion of a vessel, (4) ischemia due to occlusion from an embolus.

Proper treatment depends on proper diagnosis, which can be made in 50 per cent of the cases. Spinal puncture should be done; for if the fluid is bloody, diagnosis of hemorrhage is assured, and anticoagulant therapy must not be undertaken. Clear fluid, however, does not exclude intracerebral hemorrhage. Angiography affords a much more accurate diagnosis. It may show (1) aneurysm or arteriovenous malformation, (2) space-occupying mass, (3) obstruction of a major vessel in the brain or neck, (4) defects compatible with arteriosclerosis, (5) apparently normal major vessels.

Direct puncture of the carotid and vertebral arteries for injection of radiopaque materials is most suitable in patients under age 50 without arteriosclerosis. In older patients or in those with obvious arteriosclerosis, the risks of direct puncture may be obviated by use of retrograde brachial and subclavian injections, or by catheterization into the heart via the brachial or femoral vessels.

Bleeding Aneurysms

Patients with bleeding aneurysms disclosed by angiography probably should not be operated upon when they are in coma. About half can be handled adequately with carotid artery ligation, which is safer than intracranial ligation but not as certain to prevent rebleeding. Since arteriovenous malformations bleed from vessels with smaller pressures than aneurysms, bleeding itself is not always an indication for operation. This should depend on the severity and location of the malformation, so that one can consider the sequellae of removal of the mass.

Some bleeding may occur with brain tumors, hitherto silent, which can be disclosed by angiography. Hematomas outside or inside the brain can be evacuated at times, depending on the severity of the neurologic deficit and the location of the hematoma. Those outside the brain can usually be drained by burr holes; those inside are best evacuated by craniotomy. Bleeding in the basal ganglion or internal capsule is rarely amenable to operation, but hematomas in the temporal and frontal regions can be evacuated with benefit.

Verification of Angiography

Removal of intravascular occlusions within the head which have caused ischemic infarction is possible but is not done because damage to the brain is already permanent. Clinically it is not possible to differentiate carotid from intracranial occlusive disease. Angiography is useful chiefly in identification of the vessel involved: If the occlusion is in the carotid or vertebral vessels outside of the brain, operation may be indicated; when the patient is already hemiplegic and aphasic, operation will be of little value. But investigation is worthwhile if the neurologic difficulties recede rapidly or are truly transient, for then endarterectomy or bypass grafts may be effective in preventing recurrence.

The clinical diagnosis is aided by listening for bruit over the great vessels in the neck, by ophthalmodynamometry, and by cautious occlusion of the carotid artery below its sinus. In rare instances, direct surgical exploration of the carotid bifurcation may be indicated, but usually it is best to have angiographic verification

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of the location of the obstruction and the degree of narrowing.

It is necessary to understand that not all patients with strokes should have angiography or surgical therapy: The elderly patient who shows no improvement in a week or ten days probably should not have these tests if he has had the "conventional" stroke with sudden onset of complete hemiplegia and aphasia without bloody spinal fluid but with retained consciousness. The patient who is found unconscious in bed or on the floor with hemiplegia, dilated fixed pupils, and bloody spinal fluid certainly has had massive intracerebral hemorrhage and need not be subjected to angiography. The patient who has had subarachnoid hemorrhage with retained or quickly regained consciousness certainly should have angiography as a prelude to possible operation. When a stroke has been transient or when the evident cerebral ischemia has left no residues, further investigation is worthwhile.

Symposium

Restorative Aspects in Management of Strokes

Edward E. Gordon, M.D.

Aside from medical and surgical treatment indicated in a few of the patients suffering a stroke (dealt with in the previous papers of this panel), the vast majority of the 2 million victims must be helped by restorative measures. These are designed to exploit residual function and compensate for lost function on one side consequent to hemiplegia or hemiparesis.

Today the patient with a stroke is usually removed to a hospital where he receives largely bed, board, and shelter while riding out the acute episode. But this period does not have to be—and should not be—a passive one. Evaluation and rehabilitation of the disability begins here and is a continuing process during convalescence.

What are the essentials of this continuing process of evaluation and rehabilitation?

Taking Inventory of Residual Capacity

Along with the essential neurologic examination, the motion, sensory and visual perception, intellect, language, and other brain functions are gauged in order to define an applicable plan for restorative treatment. One looks for spasticity on the affected side. While such activity is only a stretch reflex and contributes nothing to purposive motion, it is a harbinger of some degree of returning excitability of the involved portion of the central nervous system. But if the limb muscles do not respond with a stretch reflex, the prognosis for regaining useful degree of function is extremely poor. A better prognosis and a more active program will be indicated, if voluntary function is present.

Sensory evaluation is important, because hemianesthesia compounds the disability of hemiplegia and colors the prognosis for rehabilitation. Equally important, especially in those persons regaining some degree of finger dexterity, is astereognosis, for such a defect sharply limits skilled, purposeful acts even with good finger movements demonstrable by random motions.

One-sided blindness (homonymous hemianopsia) must be ruled out; field defects are the commonest type of visual disorder in strokes. Testing intellectual function determines memory retention and attention span and indicates whether a person is trainable. Disorder in mentation should not be confused with loss of language function, which may require the help of a speech pathologist. Finally, in left hemiplegia, anosognosia to the left leaves the patient completely unaware of the existence of a left side in his view of the world about him. Failure to integrate spatial relationships

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imposes a severe defect in conceptualization and action in coping with environment. By frequent evaluation the program of rehabilitation may be adjusted to the changing picture of improving function.

Preserving Residual Capacity

Especially during the phase of complete paralysis, i.e., immediately, the joints of the affected limbs must be kept in *optimal position for function* and kept limber by exercise. The foot is maintained at right angle by foot board or splint; pressure on the heel is avoided. A "doughnut" does not solve the problem. Better, suspend the heel freely over the end of the mattress with the leg and thigh supporting the weight of the limb. The thigh is supported in neutral rotation. To avoid dependent edema of the hand, the arm is supported on pillows to promote venous return by gravity. *All* joints should be moved through complete range of motion, actively for the three unaffected limbs, passively for the affected one until useful function returns.

Mobilizing Residual Capacities

The attitude of the physician should be one of expectancy *for ability,* not for debility. As soon as the patient lying supine can raise his heel off the bed, he is ready to start training for walking. *Early ambulation,* if possible and safe, is achieved through aids employed progressively: supportive tilt table, to hand rails (parallel bars), to canes to no aids. Braces also may be in order; in a few, wheel chairs.

After the acute phase and supplementing ambulation comes the important training in self-care: getting out of bed, dressing, eating, toileting. The nurse must encourage self-help rather than give complete care to the convalescing stroke patient. Various self-help gadgets are available to reduce the handicap resulting from the disability, especially when the patient is still largely one-handed. These devices enable an ordinarily two-handed activity, like opening a can or peeling a potato, to be done with one hand. The same solution applies to clothing.

Experience has shown that painful, limited shoulders can be avoided by maintaining full range of motion, usually by passive exercises. A variant of this procedure is to strap a glove to the affected hand around a pulley handle attached to a rope, the other end of which is grasped by the sound limb. The latter provides the pull for passively elevating the affected arm via a pulley wheel. Electricity, heat, and massage are of no value for motor function or joint mobility.

Should useful function return to the upper extremity, retraining in skilled, purposeful acts should take precedence over mere strengthening. The occupational therapist can provide the suitable milieu for such aims in treatment. In the presence of astereognosis, visual control replaces tactile control in a structured training session.

It should be constantly kept in mind that the majority of stroke patients, usually paralyzed on one side, can eventually function well enough to leave their beds. For example, 85 per cent of them will walk with or without aids within two months, when early ambulation is offered. Recovery of the upper limb is less frequently adequate. But a lesson can be learned from the person who has lost an arm, for he can perform 90 per cent of his activities; hence, the emphasis on one-arm training in the stroke patient.

When speech is affected, vigorous therapy is needed. Expressive aphasia requires a different approach from receptive aphasia.

Summary

A close knowledge of the patient's functional status, preservation of his residual capacities from the outset, and training in ordinary daily activities form the pillars of sound convalescent care, and help bring the hemiplegic patient back from limbo to life. These features also have a tremendously favorable effect upon the person's will to do—no mean result.

All Who Have Meditated on the art of governing mankind have been convinced that the fate of empires depends on the education of youth.—*Aristotle*

Common Misconceptions about Disability and Epileptic Disorders

Alex J. Arieff, M.D.

Through the ages, epilepsy has been considered a sacred disease and something shameful. Even today, lay people as well as physicians have many misconceptions about it, e.g., that there is no effective treatment; that the disability is progressive; that mental deterioration is prevalent and most patients finally must be institutionalized; that the epileptic patient has an hereditary disorder and that he should not be allowed to marry; that psychiatric disorders are common in the epileptic patient; that drug treatment causes deterioration; that the epileptic child cannot attend school; that the epileptic patient cannot work and become self-supporting or self-sufficient; and last, since no one knows the cause in a given case of epilepsy, nothing can be done about the disorder in general.

Epilepsy a Symptom

One must recognize that epilepsy is not a disease but a symptom of disease or diseases. It may be the only symptom or one in association with other diseases. In the majority of instances, it is not disabling, and if disability does occur, it is usually not due to the epilepsy. As our progress in diagnosis and treatment has improved, more patients, as well as the public, are being educated in the true nature of an epileptic disorder and what can be done about it. When a patient first presents himself with an epileptic symptom, whatever the type of seizure — grand mal, petit mal, or some equivalent such as psychomotor seizure where consciousness is impaired — all necessary diagnostic measures should be carried out until it is determined what the patient's sole need is — surgery when needed or medical treatment alone, or adjuvant medical therapy. It will be found that in 60 to 80 per cent of patients the seizures can be stopped and the patient can be rehabilitated without any further therapy other than simple drugs now available.

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Faulty Attitudes

The patient, then, can be considered not disabled when adequately treated and in a remission, and he should be able to engage in any activity of normal persons, within certain limitations. When such a patient is in remission, he need not be regarded as different socially from any other person. The child should be able to attend any ordinary public school and allowed to participate in ordinary athletic pursuite of nonhazardous nature. It is advisable, of course, that the responsible individual knows that the child might have trouble. The person with an epileptic disorder or convulsive state does not require any more rest than the normal individual; it should be recognized that activity is helpful in most illnesses. The patient out of work appears to have more seizures than the one who is gainfully occupied. By and large, the ordinary patient should not be hampered by any particular diet. However, in general, alcohol should be forbidden to the patient with a convulsive disorder, although a social drink, especially with food, may not cause any difficulty in a given per cent of patients. This is, however, not true with the chronic alcoholic nor the person with a definite alcoholic convulsive state. These latter patients cannot be helped unless they totally abstain from alcohol, and many of them do not have seizures unless

they drink, even when they are off medication.

Unnecessary Restrictions

The patient with a convulsive disorder who is spell-free may engage in any type of nonhazardous occupation. Obviously, he should not operate a machine where he might injure himself or cause injury to others because of a seizure. There are numerous other types of occupation in which such a patient can function well. In general, accidents are more often caused by so-called "normal" people. It is well documented that industrial accidents are rarely caused by the patient with an epilepsy.

Many industries employ epileptics who are not seizure-free. The only problems presented are compensation and insurance laws. Driving a motor vehicle also presents a big problem. More than one state allows patients with epileptic disorders to drive a car, provided they have had no seizures for at least a year, are under competent medical care, and are checked often and regularly. Here a physician's statement is required. Again, it is rare for an automobile accident to occur as the result of an epileptic seizure, although it does occasionally.

I am a member of the Committee on Epilepsy and the Law. We know that some states still forbid marriage of epileptics. Having epilepsy should have nothing to do with an individual's right to marry and lead a normal family life. Again, the deciding factor should be whether the patient has any other types of hereditary illnesses and whether his attacks are controlled. Epilepsy is probably no more transmitted by heredity than is diabetes, hypertension, or obestity. A woman who has had no seizures over a sustained period of time may have children and be able to function normally as a good mother. Of course, if she has seizures, she should not have children, because it would be a hazard to herself as well as to her children. Advice to this effect, of course, is not often followed, but it would seem sensible from the point of view of the ideal situation.

Treatment

From Biblical times, the epileptic person's condition has been regarded as one of progressive deterioration that leads eventually to institutionalization. This, of course, is a misconception. When a patient is institutionalized by virtue of his epileptic disorder, it is because he has a deteriorating brain disease that is the cause of his disability, the epilepsy being a symptom of the brain disorder.

A series of patients were recently referred to the Epilepsy Clinic at Northwestern University Medical School from the Illinois Vocational and Rehabilitation Department because they were considered totally disabled. In most of these patients the epileptic disorder was easily brought under control by appropriate drug therapy; however, many had other illnesses that were usually the cause for disability. For instance, one patient had an accompanying severe diabetes and a schizophrenic psychosis; he would take an overdose of insulin that put him in hypoglycemic coma. Another patient had chronic brain disease with deterioration. The attacks could be stopped, but the brain disease was progressive. Another patient had a marked psychopathic state with chronic alcoholism. His attacks could not be stopped because he was not cooperative enough to be treated. Another patient was hopelessly invalided from early childhood because the diagnosis of epilepsy had been made, and the patient's family felt that nothing could be done; so the patient was neglected.

If one sees enough patients referred as epileptics, he will find they have many different medical conditions which may be more disabling. Therefore, it is unfair to stigmatize all patients having epilepsy. I have found in analyzing over 1,000 patients that in 60 per cent presenting with the symptoms of epilepsy a simple anticonvulsant drug, such as phenobarbital, Dilantin®, Mesantoin®, or even bromide, in appropriate or adequate dosage, will be effective in stopping all seizures, and the patient requires no other further treatment than supervision. In another 20 per cent with petit or psychomotor seizures, more than one drug—sometimes two and frequently even three drugs, such as the addition of Tridione®, Paradione®, or some of the succinamide drugs like Celontin®—may be needed. Seizures may not be completely stopped, and the patients may have minor relapses that are not disabling. Some may also manifest a reaction to the illness and require more psychiatric care, mainly in the form of reassurance.

In the remaining 20 per cent are the more

disabled patients with minor and psychomotor seizures, and in addition, personality disorders. A personality disorder may be a separate condition, but it may be a symptom of the epileptic disorder with periodic psychiatric abnormality. These patients need more than drug therapy, though they may be improved by it as far as their seizures are concerned. They become problems in rehabilitation.

Summary

Many misconceptions are rampant about epilepsy, a symptom of disease no more common than other chronic medical conditions. It is more frequently due to associated or complicating illnesses. More concerted effort on the part of more than one specialist is required in an attempt to salvage and rehabilitate these patients medically, socially, and occupationally.

Symposium

Emotional Problems in Convalescence

C. Knight Aldrich, M.D.

It is generally recognized that emotions play a significant role in the prolongation of convalescence. From the viewpoint of emotional development, any illness represents a return to a situation of helplessness and dependency similar to that of an infant; dependency on the physician and other medical personnel replaces dependency on the mother. It is not surprising, therefore, that the emotional response of the patient to illness is conditioned by his specific experiences during early childhood. Thus, early deprivation of affection and parental attitudes of overprotection contribute to a prolonged convalescence. The physician is in a strategic position to help the patient strike a balance so that he can accept dependency when ill and give up the protection of illness as he convalesces. Although preventive treatment requires early limit-setting by the physician and avoidance of unnecessary secondary gains, a sick person should not be too deprived of gratification of his regressive needs.

Early attitudes of shame or fear of dependency may result in the foreshortening of convalescence with a too rapid return to activity. Acceptance of illness in this type of patient is aided if the physician helps him be an active participant in his treatment, insofar as this is medically possible.

When the patient suffers from distortion or damage to the integrity of his body, as in the case of a stroke, he is susceptible not only to the anxiety that may be associated in his experience with dependency on adults, but another type of anxiety associated with damage to his sense of physical wholeness. His responses to the combination of fears may be regression to helplessness, apathy, depression, or denial of the condition. Treatment is facilitated by maintaining communication so that the patient knows where he stands and by encouraging abreaction, the expression of his feelings about the threat.

In illnesses with fixed sequelae, such as blindness or amputation, emotional acceptance is a necessary prelude to rehabilitation. Since the reaction to a loss of a body part is very similar to the reaction to loss of a loved relative or friend, the physician should encourage the patient's expression of grief over the lost part or function. Unexpressed hostility may interfere with the expression of grief and thus prolong the convalescence. Techniques of ventilation and emotional support are needed to facilitate the expression of anger and so expedite acceptance. When rehabilitation is not possible, as in the dying patient, the physician may be well advised to support denial to avoid a serious and unnecessary depression.

Summary

Preventive treatment of the emotional problems of convalescence is the best treatment, but it requires a diagnosis of attitudes as well as a physical diagnosis. To the extent that the physician integrates a diagnosis of attitudes in every patient he sees, he will be best equipped to help his patients forestall unnecessarily prolonged disabilities.

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The Physician, the Patient, and Cancer — An Abstract

Donald Oken, M.D.

Usually, when someone speaks on this topic he tells his audience "what to tell" the cancer patient. I am going to begin by saying *I don't know.* No one does. My research, moreover, indicates that we kid ourselves into thinking that we know, whereas actually we rely on opinion, belief, and presupposition. I would like to emphasize this because it is far more pervasive and intense than we realize and it has important implications for our work with cancer patients.

A Study of Opinions

My research was based on a study of more than 200 physicians. The initial finding was that there was a strong tendency not to tell patients that they had cancer. The modal policy can best be summed up by indicating that the approach was to tell the patients as little as possible in the most general terms consistent with maintaining cooperation.

But further findings seem more important. First, it became clear that policies were based on *opinions* of what was thought to be correct and not on scientific data or facts. Secondly, emotion was connected with the approach used. Strong language, reference to authorities rather than research, inconsistencies, and expectations of dire consequences following upon any policy other than one's own were clearly in evidence. Almost everyone felt his policy was dictated by clinical experience. Yet the evidence indicated that almost invariably a policy was decided upon at the beginning of practice and never changed, regardless of experience. Moreover, recent graduates were no less likely than their seniors to cite experience.

Beyond this were tendencies to avoid exploration and study. A substantial number expressed great doubt about the desirability of research, and many indicated that they would continue their policy even if data pointed in another direction. This finding is substantiated by the remarkable dearth of research to date.

It should be emphasized that these findings have nothing to do with the correctness or incorrectness of any policy. The point is that we really do not know and that in some ways we do not want to know more about this problem. The important question then is Why is this so? To get some leverage on this, it is worthwhile considering the psychology of the doctor and of the practice of medicine.

The Physician's Psychologic Problems

First, note how difficult it is for us to stand by and do nothing. One of the most difficult tasks to perform and learn is "watchful waiting." All of us have a tremendous push towards keeping busy and active. Doctors notoriously can't "take things easy."

The treatment of cancer involves long periods of observations and waiting, often with no specific therapy available. Even where there is, a period follows during which one stands by relatively powerless. This waiting, with matters taken out of our hands, is frustrating and upsetting. Further, there is often a fatal outcome, which is also a blow to our pride. We feel it as a personal failure and defeat.

Another group of psychologic factors is important — those having to do with feelings about death. Psychiatric data indicate the importance of negative and ambivalent feelings in the response to death as a major part of normal grief. The development of guilt feelings in the presence of the dying or dead also is universal. Such feelings are greatly intensified by the nature of the doctor-patient relationship that leads to close and continuing bonds with patients. Of no small importance in the devel-

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opment of this tie is the "transference" which the patient develops to his physician as an omniscient idealized person. In a life-threatening and chronic disease such as cancer this transference is apt to be especially intense and guilt-inducing.

These and similar features give rise to the intense feelings and the avoidance reactions already noted. Although avoidance and denial are natural responses to the presence of uncomfortable feelings, recognizing our underlying attitudes rather than negating them can be a great asset. Freed from our own fears, we will hear what our patients are saying to us rather than the sound of own preconceptions. These communications from the patient are of irreplaceable and unequal import as a guide to what, when, and how to talk to him.

Ideally, the time to get this information is during the diagnostic work up when key information about the strength and vulnerability of the patient can be gleaned. We can learn about past handling of illness and surgery, about present speculations and fears, the degree and kind of emotional responses arising, and what feelings there are about the disease revealed by the reaction to past experience with it in the family. It is not the over-all "strength" which is estimated so much as the specific feelings about the particular illness, its location, the type of treatment indicated, etc. Most patients today realize that complex procedures are necessary for diagnosis, and they are willing to accept temporizing "to see what the tests show," for it provides the necessary time for evaluation. This early period is one of unequaled opportunity; for it allows the physician the greatest freedom and "room for maneuver" before committing himself.

These issues become important also in the further care of the patient. By dealing with our own feelings, it becomes possible to allow ourselves to become closer and more supportive to our patients and to avoid having to develop our false rationalization that "nothing can be done" for the patient, to whom support is of tremendous therapeutic value.

Conclusion

My message, then, is that the most effective and valuable instrument the doctor has is himself and that this instrument is at its maximum utlility when he removes his own emotional blocks through self-examination and insight.

Symposium

Present Concepts in the Management of the Adolescent

Eugene I. Falstein, M.D.

In recent years increasing attention has been focused upon the adolescent, his problems, and his world. Perhaps no other single factor has contributed more to this special recognition that a greater awareness of the psychopathology that characterizes this developmental period. As a result we are seeing specialists in teen-age medical problems as well as psychiatrists who devote a major portion of their time to the understanding and treatment of the adolescent. The pediatric hospital is establishing separate facilities for adolescent patients, while the psychiatric hospitals are creating specific units or services for them. For all have recognized the need to provide adequate programming in all areas involving basic teen-ager needs. Already, there is an established adolescent psychiatric society; we may well see similar groups in other related medical fields.

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Factors Promoting Maladjustments

Adolescence is a crucial and critical period of development that constitutes the child's last opportunity to fortify himself for the demands and responsibilities of adulthood. The child who has lived for 13 to 14 years with his body

image of smallness, inadequacy and weakness, associated with long-standing dependent needs and passive wishes is poorly equipped to deal with this new crisis. Unfortunately the sociocultural forces of our present society contribute little of a helpful nature in solving the youngster's dilemma: a preponderance of immature parents; a tendency on the part of all parents to repress all or most memories of their own adolescence; a war that disrupted, displaced, or broke over 10 million families whose babies now constitute the bulk of our present adolescent population; a decline in the import and effectiveness of religion; an increase in the element of corruption at all levels; greater competition in the academic world for places in college; out-moded laws concerning school drop-out; the relative disappearance of the pioneering spirit and the greater general wealth with its softer, easier, more indulgent ways.

All these and many other factors have contributed from without to promote maladjustment and emotional difficulties in the adolescent and have complicated and enhanced the internal struggles attendant upon the biologic and psychologic demands.

Improved Methods of Management

The far-reaching advances in psychiatry and spread of knowledge about it have been most responsible for broad changes in the approach to the management of the developing child. New agencies that are part of the school, the community center, the court, the hospital, the camp, and the general community (child guidance clinics) are responsible today for earlier screening, detection, and management of problems. The physician too, particularly the pediatrician, has played a very important role through his increasing awareness.

Only a few decades ago many of the sick adolescent population were secluded, neglected, carried along, or hidden away until they attained the late teen-age levels when one is expected to begin to fend for one's self. Totally unprepared to face even the minimum requirements of adulthood, they became the bulk of state hospital first admissions, or ended up in other custodial institutions, often too late to be helped by the available therapeutic methods of the times.

While there continues to be a very serious shortage in the field, today more psychiatrists, psychologists, social workers, school counselors, and other trained people are available to provide individual and group therapy of the adolescent. As Dr. Lawrence Kubie has so aptly put it, every adolescent at one time or other needs an ally to turn to, but it must be one specially trained to meet his emotional needs, a role that cannot be filled by the ordinary teacher, minister, or pediatrician.

More and more adolescent children require treatment in an environment other than the home. Unfortunately there are too few available resources for this purpose. Residential treatment centers and schools, hospital adolescent units and services, and a sprinkling of adequate foster homes are scattered sparsely through a few communities. A small number of these places provide a haven when acute intervention is imperative; others are available on a more planned basis. While some are geared towards the eventual return of the adolescent to his home, hopefully after concomitant or collaborative parent psychotherapy, most of them attempt to achieve the self-sufficiency and autonomy that is the ultimate goal of every mature adolescent. His optimum placement eventually should be in a place of his own, emancipated from and independent of the parents and the infantilizing forces that they promote, encourage, re-awaken, or represent.

Individual psychotherapeutic management of the adolescent and his problem will depend, of course, upon a multitude of complex factors including age, degree and type of psychopathology, parental cooperation, the basic distrust and resistance in the child, and ultimately on the skill of the therapist.

I Feel An Earnest and humble desire, and shall do 'till I die, to increase the stock of harmless cheerfulness.—*Charles Dickens*

The Challenge of Parkinsonism

Louis D. Boshes, M.D.

In this country there are an estimated 400,000-500,000 cases of Parkinson's disease. Some estimates run to 1,500,000. Also there is a variable geographic incidence of 1:600 for western and midwestern states whereas there is a 1:1500 ratio in eastern states.

The disease, per se, does not kill, but it disables great numbers, especially those with no symptomatic support or control. No patient has ever been cured of parkinsonism; but every patient warrants help for his three major and classic symptoms, tremor, muscle rigidity, and poverty of movement.

Since the burden of care of the vast majority of sufferers from Parkinson's disease falls upon the general practitioner, it is quite understandable why he must keep abreast of the latest advances in treatment. Moreover, he sees the patient from the start of the illness when most can be done to prevent later disabilities through proper orientation of the patient and an intensive program of therapy. The physician can help his patient understand the nature of his illness so that he will not be left to rely on stray bits of information or misinformation from neighbors, friends, magazines, or plain heresay. When he knows that his illness is not inherited nor contagious, he will be relieved, as he will be also when it is explained that speech and mental faculties are not affected and that there is no paralysis nor numbness.

For the first major symptom of tremor there are newer and better medications of control. For rigidity, there are new medications, but physiotherapy and exercise are essential. Even for slowness of movement specific agents are available. Better drugs continue to be created by pharmaceutical houses.

For cases of Parkinson's disease that do not respond to conservative therapy there are now specific surgical procedures for relief of tremor and rigidity. Within the past few years new surgical procedures have aimed at a specific attack on the globus palidus. Ligation of the anterior choroidal artery has been abandoned because of the numerous complications or return of symptoms within six months to one to two years. The more recent method of chemopallidectomy by procaine oil, alcohol, leukotone, electro-coagulation, or isotope is less hazardous. However, more time will be required for evaluation of the lasting value of these procedures. Thus far, favorable results have been obtained usually in younger patients and in those in whom there is unilateral involvement. Unfortunately the older patients have the worst form of bilateral symptoms and are in the greatest need of neurosurgical help. Because of the risk of hemorrhage and other complications, these are the very patients most neurosurgeons prefer not to treat.

The family, too, should be oriented when the patient is seen initially. To merit the continued cooperation of the patient, the physician must exercise true concern for his needs and welfare. He must, as already stated, keep abreast of the latest advance in medication and pay close attention to the three essentials of therapy for all cases of parkinsonism — medication, physical therapy, and exercise. The patient does not expect a cure but is appreciative of any betterment of his condition.

Medication is the first essential of therapy, and there is a growing number of effective remedies. Physiotherapy is another essential and should be strongly recommended to every patient suffering from rigidity. The patient must be made to realize not only its value but also the reason he must use it early and continuously since, once contractures develop to an irreversible degree, it becomes useless. Exercise by the patient, the third component of the three essentials of therapy, should be stressed both as a means of preventing later contractures

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and as a means of correcting those acquired.

During the long course of the illness the patient may be bothered not only by his symptoms but also by the endless complications older people fall heir to, such as memory loss, headaches, dizziness, weakness, depression, nervousness, fear of the future, insomnia, and loss of weight. No one is better equipped to comfort the patient than the family doctor who knows his background, temperament, and failings and has repeatedly helped him in the past. Thus the general practitioner can provide therapy for both physical and emotional complaints; this is within the scope of every physician.

In various university centers, including Northwestern University Medical School and the Neurophysiology Laboratory at the Minneapolis Veterans Administration Hospital, scientists are working on the use of electronic equipment to measure and record rigidity and tremor. At Northwestern, for example, changes in voice and speech patterns and the effects on the body of changes in respiration are being studied as well. Also, some of the psychiatric aspects, such as depression seen in Parkinson's disease, are being evaluated.

Finally, a National Parkinson Foundation and a Parkinson Disease Foundation have recently been created. In the Federal Government, the American Medical Association, and other agencies, there has been an awakening to the pressing needs of the rapidly growing numbers of the aged and infirm. This newly aroused interest cannot fail to be ultimately translated into better conditions for care and treatment of patients with Parkinson's disease.

Symposium

The Challenge of Multiple Sclerosis

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The challenge of multiple sclerosis is due to modern medical advances in dealing with illness and improved diagnostic methods. In less than the 100 years since Charcot published the first clear account of the clinical and pathological manifestations of the disease, its status has changed from a rare disorder to one of the common disabling disorders of the nervous system.

It is a chronic disease, usually beginning in early adult life, ordinarily of insidious onset and frequently marked by exacerbations and remissions. Although 75 per cent of the patients will have two attacks in a five year period, remission from clinical symptoms for as long as 15 years has occurred in 5 per cent of patients. The longest remission recorded is 37 years. The more frequent signs include visual defects due to retrobulbar neuritis, spastic paraparesis with loss of abdominal reflexes due to involvement of the posterior and lateral columns of the thoraco-lumbar cord, and ataxia, intention tremor, and nystagmus due to involvement of the cerebellar pathways.

Pathologically it is characterized by widespread patches of demyelination with *relative* sparing of axis cylinders and subsequently a profusion of astroglial fibers in the areas of demyelination.

Clinical study of the disorder has produced no definitive leads to the etiology of multiple sclerosis. Most etiologic studies involve the cause of demyelination in the nervous system. Among the numerous central nervous system disorders whose pathologic picture include demyelination are diffuse sclerosis, neuromyelitis optica, postvaccinal encephalopathy, metachromatic encephalopathy, and acute disseminated encephalomyelitis. It has been the hope of some workers that a common etiologic agent or pathophysiologic mechanism could be held responsible.

Although the disease has never been transmitted from one subject to another, there are proponents for theories of infection. There are

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isolated reports that a treponema is present in the pathologic sites. Experimentally, the virologists point to canine distemper, the pathologic study of which indicates an affinity of the virus for certain parts of the white matter of the central nervous system. One of the postvaccinal forms of encephalopathy follows injection of antirabies vaccine. Other neuropathologists consider this a hyperergic response. Numerous preparations of homologous and heterogenous ground brain substance with adjuvants have been used to produce experimental allergic encephalopathy. Although no specific antigen or antibody has ever been isolated in these experimental studies, it is assumed that this demyelination is an allergic phenomena and that this is the basis for multiple sclerosis. It must be noted that the experimental allergic encephalitis takes about three weeks to incubate while the usual postvaccinal (infectious) encephalopathy occurs 10-13 days following inoculation (infection). It is probable that in these cases the antigen is the virus itself, not an antigen formed by virus acting on the central nervous system.

Rather than belabor the details of these studies, sufficient statements have been made to indicate that it is fallacious to consider demyelination a singularily produced pathologic phenomenon. Although many diseases may be grouped together as demyelinating diseases, the etiologic agents are probably different. If the etiology is the same, then there must be differences in amount and length of exposure, degree of body resistance, and further, differences due to vascular, electrolyte, and other metabolic factors operating at the time the etiologic agent is producing its havoc. (Lead intoxication produces encepholopathy in children rather than the peripheral neuropathy found in adults, principally because of the instability of the blood pH in children.)

It is my impression that the wealth of knowledge in the anatomy of the central nervous system obtained with the use of electron microscopy in recent years, coupled with insights of neurochemistry will lead to the isolation of the etiologic agent in the not too distant future. We now know that myelin is an oligoligodendroglial cell spiralled about the axis cylinder (Schwann cell in the peripheral nerve), and further, in what structures critical metabolic transfers occur.

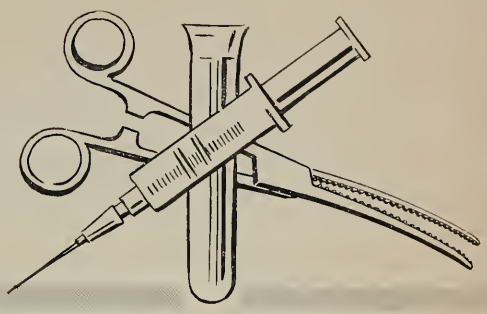
Over 200 therapeutic agents and regimes have been devised for multiple sclerosis, but to date no outstanding success has been achieved. I am not optimistic that an empirical agent will be found before agreement on the etiologic agent or pathophysiologic mechanism has been determined.



According to the ISMS Constitution . . .

Section 4. The Council Shall be the board of censors of the Society. It shall have jurisdiction over all questions of ethics and in the interpretation of the laws of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. All questions of an ethical nature before the House of Delegates or the general meetings, shall be referred to the Council without discussion. It shall hear and decide all questions of procedure affecting the conduct of members on which an appeal is taken from the decision of a component society.

The decision of the Council shall be final except that an appeal may be taken by a member charged with misconduct as provided for in the Constitution and Bylaws of the American Medical Association.



Anesthesia Conference

Cook County Hospital

From Surgical Emergency to Medical Crisis

Vincent J. Collins, M.D., *Chicago*

The Task of the Anesthesiologist who is confronted with the management of a surgical emergency is not infrequently complicated by a superimposed medical emergency that has been precipitated by hasty preparation of the patient for surgery. Even in the face of seeming catastrophies, a few moments spent in more careful evaluation of the patient may result in more effective preoperative preparation, and this may mean the difference between success and failure in the intraoperative and postoperative periods. This preoperative case report illustrates rather vividly how such ill-advised preoperative preparation of a patient can produce a medical crisis which is of itself a greater threat to the patient, perhaps, than the surgical emergency for which he is to be operated upon.

Case Report

This patient, a 66 year old colored male, had undergone a right pneumonectomy in September, 1960, for carcinoma of the lung, and had subsequently been irradiated for recurrence. In October, 1961, while visiting the chest clinic, he experienced sudden severe right chest wall and upper abdominal pain. He was immediately readmitted to the chest surgery ward for work up. The only significant recent history was that of vague epigastric and right chest pain for the two weeks prior to admission.

Physical examination revealed a rather emaciated Negro male in acute distress with a blood pressure of 118/70 mm. Hg and a pulse reported as 90/min. There were the expected decreased breath sounds and vocal fremitus over the right chest, the left chest being clear to percussion and auscultation. The heart examination was negative, while the abdominal findings included hypoactive bowel sounds, tenderness, guarding, rigidity and rebound tenderness confined to both upper quadrants. A stool benzidine test was negative, and no blood was obtained by Levine suction.

The hematocrit was 44 per cent, and urinalysis revealed a specific gravity of 1.024 but no sugar, acetone, or protein. Urinary and blood amylase were within normal limits, and the CO_2 combining power was 52 cc./100 cc. Four views of the abdomen showed free air in the peritoneal cavity, and the patient was transferred to a general surgery ward with a diagnosis of perforated peptic ulcer.

On this ward the blood pressure was found

to be 104/70 mm. Hg, but the peripheral pulse was now reported to be 180/min. and possibly irregular. Auscultation confirmed the irregular irregularity of rhythm and the rate, which was exactly twice that recorded on admission to the chest surgery ward. The remainder of the physical findings were identical to those found on the earlier examination except that bowel sounds were now absent, and there was definite resonance over the liver.

Latent Heart Disease

Because of the high hematocrit and urinary specific gravity, the patient was given 2 units of plasma and 1 liter of 5 per cent dextrose in normal saline over a period of about one and a half to two hours in preparation for the anticipated surgery. In the meantime an electrocardiogram was requested by the anesthesia department and substantiated the clinical impression of atrial fibrillation with a rate of 188/min. However, following the administration of the intravenous fluids, crackling rales could be heard over the previously clear left lung field. Now the patient was given desacetyllanatoside (Cedilanid-D) 0.6 mg. intravenously, and one and a half hours later, when the pulse had dropped to 140 and the rales seemed to be clearing, a second 0.6 mg. was given. The axillary vein was cannulated so the venous pressure could be monitored throughout surgery. The patient was premedicated with atropine 0.4 mg.

Comment

Simply because a patient has a "surgical emergency," there is a tendency to focus attention on the site of the emergency and to disregard the physical status of the patient as a whole. It must be constantly reemphasized that it is the status of all organ systems that determines how the patient will respond not only to the stress of the emergency itself but also to treatment of that emergency. In the attempt here to rapidly replace the fluids and electrolytes lost through the "peritoneal burn" of the perforated peptic ulcer, the compromised cardiac status was not appreciated until acute congestive failure became evident. Fortunately, the presence of such a medical emergency was realized and certain intraoperative disaster averted; but nonetheless, needless time was lost in correcting the medical problem before the original surgical emergency could be treated.

In a 66 year old patient, and more particularly in one with cardiac disease, administration of fluids must be undertaken carefully, as fluids alone can (and here did) precipitate failure by providing an added burden on the heart. The replacement should have been done more slowly and judiciously and should have been done using half-concentrations of better balanced solutions, such as Ringer's solution.

An additional factor that makes fluid replacement even more hazardous in this patient is the absence of one lung. A normal person can accommodate up to 1,200 cc. of fluids in the lungs without the appearance of failure. Here this accommodative mechanism for handling excessive fluids is severely handicapped, and in addition, the presence of fluids in the lung also handicaps the gas exchange mechanism, oxygen transfer being slowed by 50 per cent, carbon dioxide somewhat less.

Management of the Cardiac Status

First, it is a good standing rule that when the ventricular rate is greater than 100, except in the face of blood loss or undue sympathetic stimulation, the cause lies in the heart itself, which, when decompensated, increases its rate in an effort to increase cardiac output. In 75 to 80 per cent of the cases of atrial fibrillation the cause is cardiac failure or arteriosclerotic heart disease or both. In the matter of digitalization, desacetyl-lanatoside does not accomplish this rapidly enough for the surgical situation. Ouabain or acetyl strophanthin are the drugs of choice having an onset of action of four to ten minutes. Digitalization is complete in 15 minutes with these drugs, and they have the added advantage of being of very short duration; thus, at the completion of surgery and the emergent situation, medical management may be instituted without regard for the previously used drugs. Lastly, the use of an anticholinergic drug must be weighed carefully in such a cardiac status, for these drugs may diminish whatever vagal block is present and cause an even greater increase in rate, which alone could precipitate acute failure.

Choice of Anesthesia

Concerning choice of anesthesia in this already complex situation, it must be emphatically stated that local anesthesia is not necessarily the anesthesia of choice. There will be pain, and pain definitely decreases tracheobronchial ciliary activity and causes bronchoconstriction; both of these effects result in increased incidence of postoperative atelectasis. General anesthesia is the anesthesia of choice, and this should consist of cyclopropane administered endotracheally. Moderate positive pressure, insufficient to impede venous return to the heart, will help to control pulmonary edema and to improve gas exchange. Light cyclopropane anesthesia has a positive inotropic effect on the myocardium. It has a parasympathomimetic effect that promotes slowing of the heart. In addition, it has a salutary effect on the microcirculation and the capillary bed.

Summary

In summary, in surgical emergencies, more careful evaluation of the patient will lead to better preoperative preparation and will avoid precipitation of medical emergencies that are only secondary to such preparation. In this case a good program would have included:

(1) More rapid digitalization prior to fluid replacement
(2) Slower fluid replacement
(3) Use of balanced solutions that would replace all of the electrolytes lost
(4) Judicious use of smaller amounts of belladonna drugs
(5) General endotracheal cyclopropane anesthesia

Varix Hemorrhage

The observation that repeated hemorrhage frequently occurred in patients with varices and hiatus hernia supports the presumption that reflux of gastric contents with resultant esophageal inflammation is a factor in precipitating varix hemorrhage since reflux is a frequent accompaniment of hiatus hernia. The frequency with which esophageal inflammation occurred in patients with ascites is probably explained by the fact that increased intra-abdominal pressure alters normal subdiaphragmatic relationships, rendering the cardiac mechanism less efficient. The integrity of the esophagogastric junction is not solely dependent upon an intrinsic mechanism, but anatomic relationships in the immediate vicinity are in part responsible for maintaining the integrity of the gastroesophageal closing mechanism. It is probable that change in liver size in either direction also interferes with the usual relationships around the esophagus which ordinarily helps prevent reflux.

The incidence (46%) of inflammation in association with recent variceal hemorrhage noted in this study is in agreement with the incidence of ulceration found in necropsy material by Wagenknecht (43%) and Chiles (56%) and serves to strengthen the premise that in some cases esophagitis is an important factor in producing hemorrhage. Finally, 20% of our patients with varices had superficial inflammation but had never bled, emphasizing the fact that a combination of factors having different multiples in individual cases is necessary to complete the unknown portion of the equation which eventually equals the catastrophe of hemorrhage from varices. *Captain Edwin Polish, MC, USA, and Colonel B. H. Sullivan, Jr., MC, USA. Esophagitis Associated with Hemorrhage from Esophageal Varices. Ann Int. Med. May 1961.*

Leukemic Remissions

In one-third of all cases described as leukemic remissions in the literature the remission could be attributed to the presence of purulent infection. Even a higher percentage of apparent cures or remissions of sarcoma and cancer are traceable to concomitant purulent abscesses, pneumonia or erysipelas. Perhaps the bacteria causing the infection contain a specific virus for the particular cancer cell, enters it, cause disease of the cancer cell and its destruction. *Louis H. Nahum, M.D. Viruses and Cancer. Connecticut Med. May 1961.*

The View Box

Franz Gampl, M.D., *Chicago*

A 49 year old Negro male complained of severe headache, dizziness, and occasional vomiting of three weeks' duration. He also had a gnawing pain in his left hand.

The physical examination showed some clubbing of the fingers. The blood pressure, temperature, pulse, and the physical findings over the chest and abdomen were normal.

A radiograph of both hands showed the radiolucent defect in the third metacarpal bone of the left hand.

What is your diagnosis?

1. Enchondroma
2. Osteomyelitis
3. Metastasis
4. Bone cyst

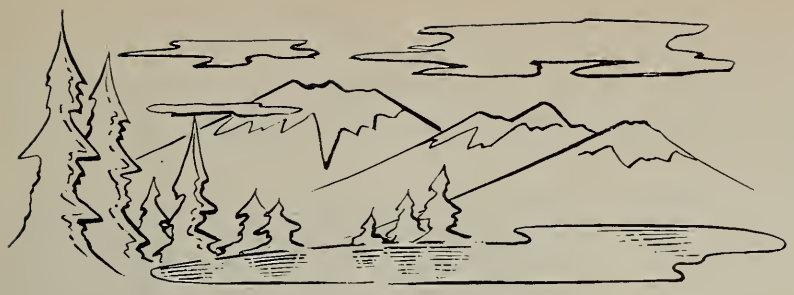
(Continued on page 345)



FIGURE 1. Roentgenogram of left hand showing defect in the third metacarpal bone.

From the radiology department, Cook County Hospital

Land-locked Crew I can lay no claim to any great discovery, but I was a member of the crew in several of the ships engaged in exploration of the Islands of Langerhans, and I must admit to a degree of pleasure in recalling these adventures. *Russell M. Wilder, M.D. Adventures Among the Islands of Langerhans. J. Am. Dietet. A. April 1960.*



MEDICINE in the OUT-OF-DOORS

FISHING GADGETRY

"You will find angling to be like the virtue of humility, which has a calmness of spirit and a world of other blessings attending upon it."

—Izaak Walton

Julius M. Kowalski, M.D., *Princeton*

The barefoot boy with willow stick, string, and bent pin is the symbol of the coming fisherman. Many carefree hours will he know which can be recalled with pleasant reverie in later years. As growing up becomes more vexing, so will his recreational gear become more complex — at times to the point of being nightmarish. Using a bamboo pole with plastic bobber and proper-sized hook is an easy forward step. Then in rapid transition follow the spincast, casting, and fly rod outfits. In just this manner, millions of Americans — boys and girls, men and women — each year seek out the virtue of humility.

To assist them in the gentle, contemplative art are thousands of dedicated biologists, professionally trained and seasoned with experience, whose mission is to shorten the time between bites. Their perseverance is awe-inspiring and enthusiasm boundless as they work for governmental agencies, state and federal; yet for these sterling attributes they are among the most poorly paid.

The counterpart of this group is the publicist in the several communications media who digests the scientific jargon, statistics, and graphs, and makes it understandable for the average person. His efforts are most commendable, for without him humility would turn to rancor. These are the people who through first-hand reports insure fishing success or failure in a given lake or stream — the *where* of the quest. Experts in their work of love, they go to great lengths to inform on *when* and *how* so that even a first-timer might feel the electrifying tug at the end of his line.

To have so many striving to a common end, it would appear that failure for the fisherman would be unknown. But the element of uncertainty exists; the variables are many — some are poorly understood, others totally unknown. The challenge is ever present; this makes fishing a sport. No clear answer can be given each time to the where, when, and how of fishing.

On strange water the best procedure is to seek out a guide. It is his business to know the productive spots that the novice might find only after much fruitless effort in the vastness of barren water. The advice from natives is second choice. In the discussion designed for success appear such expressions as "point of land," "drop-off," "bar," "hole," "weed bed," and "snags" which indicate good habitat. These favorable areas are often located by simple observation, but at other times it proves to be a task to find them. This is true of waters that one feels he knows with certainty, almost like his own back yard. To determine depth, the plumb line has been used for years. But this

method is time-consuming and after several hours, it is downright tedious to try to find *that* hole. Another variable worth knowing is water temperature. This can be taken with an ordinary thermometer or one specifically designed for under-water temperatures. By recognizing and properly interpreting the variables of habitat, water depth, and temperature, one is on his way to that calmness of spirit.

Now in this era of atoms and electronics two pieces of equipment have appeared to help determine more quickly and accurately those two important variables of fishing — depth and temperature. It can be argued that such mechanization is an invasion of sanctity. But there are overwhelming numbers whose fishing time is limited, whose periods for the sport, of necessity, are the poorest of the year, namely, the summer months. For such a person, the use of a depth finder and electronic thermometer is a big help on any water.

Results obtained from use of this equipment will be most shocking to those who think they know their home waters. Lake-bottom contours will be revealed that were never suspected before. Trenches or holes only a few feet in width can be discoverd with possibly good habitat. Points of land with sloping shoulders will run out into the lake farther than previously suspected. The edges of drop-offs can be seen with remarkable clarity. This is all accomplished through electronic principles that were put to marine use during the war. The same techniques are now used but are made conveniently portable and transistorized. There are many varieties of depth finders and fish locators. They all work on the same idea. Some only determine depth; others do this and also reveal bottom type — roek, sand, or mud — and even pick up signals from individual or schooling fish. Commercial fishermen and biological survey crews have used similar equipment for years, but it is heavy and built directly into their vessels. The depth finders and fish locators referred to here are light and compact, designed to be used in the average fishing boat or canoe — wood or metal.

For a family that can spend only two weeks out of the year at fishing when father must take the vacation assigned to him, a fish locator is an expensive but worthwhile purchase. With reasonable care and only occasional battery replacement, it will last for years.

The transistorized thermometer was developed to give instantaneous readings at varying depths. Every fisherman recognizes the importance of such findings since he knows that certain species will be found in water at a given range of temperature. The determination of the thermocline, that all-important layer of our stratified lakes (and a great number of them are in this classification), is readily and accurately determined with an electronic thermometer. This is light, its cable marked off in foot intervals, and it will stand normal wear for years. The transistorized unit is powered by a small mercury battery like that in hearing aids and is available from most drugstores. This instrument and the depth locator are precision equipment. The combined cost is about equal to two weeks' cottage rental at one of the northern lakes.

Expensive? Yes. Necessary? No. But this equipment can be used for many years. Since achievement is good medicine in every walk of life, the numerous failures we have come to expect on fishing trips may now be turned to partial successes. Yes, and even partial success from angling has a world of other blessings attending upon it.

Sky Delivery No airline, except for short trips and under very special circumstances, is willing to give a seat to a woman who is more than 32 weeks pregnant. This rule seems reasonable on all counts; but because some women are not entirely accurate in their recollection, most operators prudently instruct their cabin staff in how to help at a normal birth. *Invalids by Air. Lancet. April 1, 1961.*

The View Box— diagnosis and discussion *(continued from page 342)*

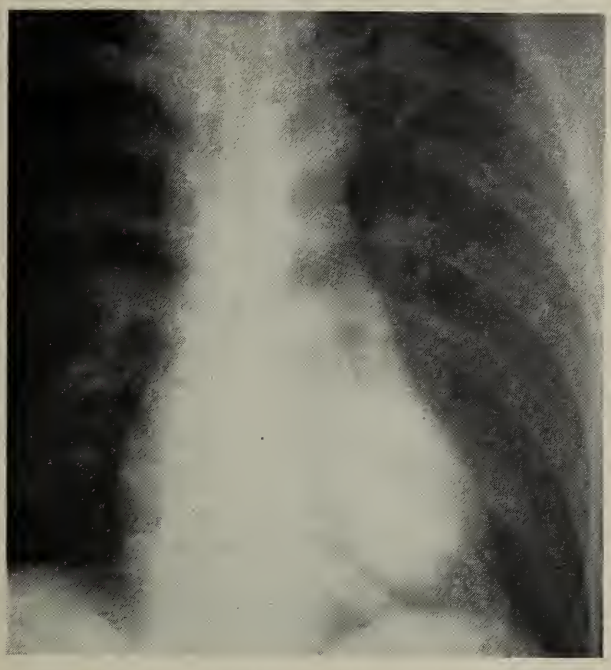


FIGURE 2. Rounded density in left lower lobe behind the cardiac shadow was site of primary carcinoma.

The diagnosis is metastasis to the third metacarpal bone of the left hand. Spading of the end phalanges and periosteal reaction along the shafts of the metacarpal bones as an expression of pulmonary osteoarthropathy are also present.

An excision biopsy revealed adenocarcinoma. The primary site was the lung. The chest radiograph (Fig. 2) shows the rounded density in the left lower lobe behind the cardiac shadow. At autopsy, metastatic deposits were found in the brain, the meninges, and both adrenal glands. The gastrointestinal tract was normal on roentgen and post-mortem examination.

Differential Diagnosis

1. *Unicameral bone cyst* is located in the shaft of the bone and does not affect the epiphysis.

2. *Enchondroma* is often multiple in the bones of the hand. The lesion shows sharply defined borders. Stippled calcifications within the radiolucency, if present, are pathognomonic.

3. *Osteoid osteoma.* The density of the bone is increased; periosteal reaction and radiolucent nidus are characteristic.

4. *Epidermoid cysts* are sharply defined, radiolucent defects with a surrounding border of bone sclerosis, always located in the distal phalanges.

5. *Giant cell tumor* has a multicameral, trabeculated appearance. Expansion of the cortex and cortical destruction is common. The appearance is characteristic but not pathognomonic.

6. *Brown tumor of hyperparathyroidism* may simulate a metastatic lesion. The subperiosteal bone absorption at the phalanges of the hand will serve to suggest the diagnosis.

7. *Tuberculous, syphilitic, and nonspecific osteomyelitis* show periosteal reaction and commonly some reparative bone sclerosis.

8. Rare primary neoplasms of the bones of the hand, the osteolytic type of osteogenic sarcoma, Ewing's sarcoma, reticulum cell, and lymphosarcoma, are radiographically indistinguishable from metastatic disease in most of the cases.

Discussion

Metastatic lesions in the bones of the hands and feet are rare. Their radiographic appearance is that of bone destruction without periosteal reaction. The borders of the lesion are indistinct and the destructive process commonly extends into the adjacent joint. Fifty per cent of these tumors have their primary site in the lung. Carcinomas of the breast, the kidneys, and other organs follow in diminishing frequency.

It is not uncommon that the metastatic process in the hand causes the first symptom of the previously silent primary lesion.

Radiotherapy is of palliative value.

Further Reading

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An Unusual Case of Pyemia

Stanton G. Polin, M.D., and Nathan N. Crohn, M.D., *Chicago*

The Recent Occasion to care for a patient that presented many baffling diagnostic and therapeutic problems serves as the impetus for this report.

A 60 year old Negro woman was admitted on the medical service because of persistent sharp pain, which began eight days after a fall and radiated from the lumbar area to the left calf. Examination revealed a well nourished woman with tenderness at the lumbosacral area and the left sacroiliac joint, and along the inner aspect of the left thigh.

Hospital Course

A few days after admission the abdomen became tender to palpation associated with guarding, mainly in the right upper quadrant. The temperature ranged to 103 F. and the white count to 18,000 per cu. mm. Scout films of the abdomen were interpreted as normal. A soft bulge with crepitation below the left inguinal ligament was noted and interpreted by an intern as a femoral hernia with bowel containing gas.

Because the most prominent symptoms were the persistent pains in the back and in the left leg, an orthopedic consultant saw the patient and offered the impression of acute synovitis of the left hip. X-rays of the lumbar spine, sacrum, and left hip showed normal osseous structures, but near the hip were several large radiolucent shadows interpreted by the radiologist as a loop of bowel in a left femoral hernia (Fig. 1).

Two weeks later she first presented tenderness and rebound tenderness in the left lower abdominal quadrant. A surgical consultant diagnosed perisigmoiditis secondary to sigmoid diverticulitis or perforated carcinoma and an incidental incarcerated femoral hernia. Proctoscopy to 20 cm. revealed no abnormalities. Surgery was advised. The left lower quadrant tenderness became progressively more pronounced and the temperature rose. Advice to perform laparotomy was rejected by the attending physician primarily because of his reliance on the orthopedic diagnosis but also because of the absence of more specific localized findings. The patient remained in poor general condition for about ten days and then began to improve somewhat for the ensuing seven days. A barium enema showed diverticula of the descending colon and sigmoid (Fig. 2).

Treatment

The patient's condition again deteriorated and surgery was finally permitted. Through a lateral incision in the left lower quadrant the peritoneal cavity was entered. The sigmoid colon was edematous and fixed to the posterolateral abdominal wall. The attachment was incised and a retroperitoneal abscess was entered and drained. There was no femoral hernia. The cultures of the pus grew out *Proteus mirabilis* and *Aerobacter aerogenes.*

During the postoperative period the left inguinal fold became obliterated and tender, presumably due to extension from the abscess. Eight days after the first operation, the left upper thigh was incised anteriorly under local anesthesia, and a deep abscess between the femur and the femoral artery was drained. Cultures showed *Proteus mirabilis, Bacterioides* and *Streptococcus fecalis.* Twenty-three days later the patient again became toxic, and 33 days after the first operation another retroperitoneal exploration yielded no pus, but the thigh

Department of surgery, Michael Reese Hospital and Medical Center

incision was enlarged to permit more adequate drainage. The patient seemed to be recovering but then developed an independent deep abscess on the lateral aspect of the right thigh. This was drained 62 days after the first operation, and the pus again yielded *Bacterioides.*

During the patient's very debilitated period (serum albumen two grams per cent) she developed a huge sacral pressure sore. This ulcerated area reached maximum dimensions of 16 x 12 x 2 inches. Cultures from its obviously infected base yielded *Bacterioides* and *Streptococcus fecalis.* The area enlarged rapidly, with undermining, necrotic tissue, and pus. Mechanical and chemical debridement were undertaken several times a day.



FIGURE 1, Gas shadows near left hip below inguinal ligament. These were interpreted as bowel pattern in a femoral hernia but proved to be gas in an abscess.



FIGURE 2. Diverticula of the descending colon and sigmoid shown following barium enema.

Discussion

It is not commonly appreciated that skin grafts can be applied on purulent areas with a high percentage of successful "takes." When the wound finally developed some semblance of cleanness but still was bathed in pus, pinch grafts were applied. About 90 per cent of the grafts were successful, and the purulent areas began to recede rapidly. Grafts even "took" successfully on exposed sacrum which, in some areas, was devoid of periosteum.

The organisms cultured are those of the normal flora of the colon. Apparently the source of the retroperitoneal abscess was from a perforation of the sigmoid as had been postulated. The abscess below the inguinal ligament was most likely an extension of the retroperitoneal abscess and the dominant organisms of each, any of which could produce gas, were the same. Sixty-two days later the patient developed a large abscess on the contralateral hip with gangrene of a portion of the origin of the vastus lateralis muscle near the greater trochanter. This abscess also contained *Bacterioides.* This infection could have developed only by hematogenous spread, although repeated blood cultures were negative. Culture from the sacral pressure sore also revealed the same dominant organisms.

This case illustrates the well known symbiosis between *Bacterioides* and *Streptococcus fecalis.*[1] Until the past few years *Bacterioides* infections were thought to be quite uncommon, but the awareness of the need for frequent subculturing and transferring of any in vitro growth has frequently demonstrated this organism in infections originating in the nasopharynx and in the respiratory, genitourinary, and intestinal tracts.[2]

Summary

1. A case of pyemia from which gas-forming organisms were repeatedly cultured is reported.
2. It is possible to misinterpret roentgenographic gas patterns below the inguinal ligament as a hernia rather than an abscess.
3. The successful covering of a large decubitus ulcer with pinch grafts applied even to bare areas of bone and areas covered with pus is described.

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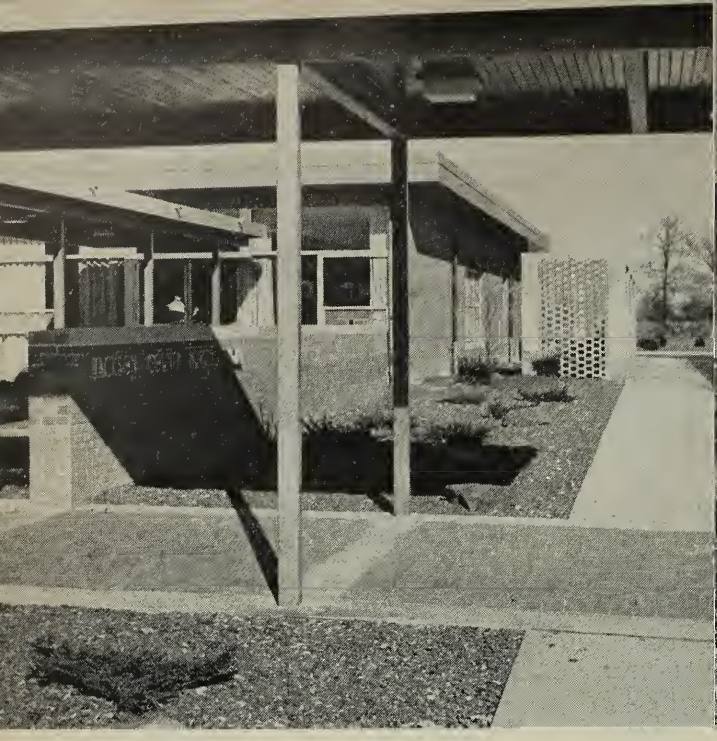


FIGURE 1. Front view of the Jackson County Nursing Home in Murphysboro.



FIGURE 2. Dining room of the Jackson County Nursing Home.

(Photos courtesy of the Southern Illinoisan)

The Jackson County Nursing Home

William G. Ridgeway

In Murphysboro, Ill., population about 8,600, is the Jackson County Nursing Home, one of the best nursing homes in the United States. Recently completed, it provides nursing home facilities for 130 patients at $150 per month, including all items except doctor bills and the cost of drugs. This article relates the history of the idea which became a reality.

Early in 1957 the Board of Supervisors of Jackson County were notified that its 32-bed nursing home, Sunset Haven, in Carbondale did not meet the standards required by the fire marshall's office in Springfield. The estimated cost to meet the standards was between $100,000 and $150,000.

Sunset Haven had been operated as a nursing home for some years, having been converted from the county poorhouse. The county farm was operated in connection with the nursing home. Facilities were inadequate to deal with the demands of the citizens of the county; so the board, after much thought and discussion, sold the farm and Sunset Haven to Southern Illinois University at a negotiated price of $88,000.

The Nursing Home Committee of the Board of Supervisors felt there was a need for a new nursing home and held meetings with interested public citizens. Many architects were consulted, and the board finally employed Pearce and Pearce, Inc., Architects and Engineers, of St. Louis. They determined that a bond issue of $975,000 would be sufficient to construct and equip with furnishings a new 100-bed nursing home believed ample to meet the needs of the county.

The committee and a citizens' committee, headed by The Rev. Charles E. Howe, Presbyterian minister in Carbondale, and Father Angelo Lombardo, priest in Murphysboro, together with the Midwest Securities Co., Chicago, employed by the Board of Supervisors as fiscal agent, compiled information for the public, and the $975,000 bond issue was submitted

States Attorney, Jackson County

to the voters of the county. The firm of Charles and Trauernicht, St. Louis, was employed as attorneys to approve the bond issue, and a special election was called in conjunction with the April primary election in 1958. The voters of Jackson County by a majority of 564 votes approved the bond issue.

Meantime, the Nursing Home Committee had visited the Randolph and Monroe county nursing homes and with the architects had discussed the new nursing home project with the Illinois Public Aid Commission and the state Department of Public Health. State funds of about $100,000 were available to aid in the construction. It was further learned that the standards required by the Hill-Burton Act would increase the cost by about the same amount. The Board of Supervisors decided to seek Hill-Burton funds largely because the nursing home would meet the standards for many years, and expert advice and supervision would be available. Building a nursing home was found to be a relatively new field.

Bonds for building the Jackson County Nursing Home were sold in the amount of $900,000. The remaining $75,000 authorized by the election may later be used in building an additional 30-bed wing. The nursing home has been so constructed that this wing can be built just for the cost of its construction, since all other facilities will be adequate.

The site selected for the nursing home was at the edge of Murphysboro on old Route 13, in Somerset Township. The Murphysboro Chamber of Commerce paid one-half the purchase price of the approximately 20-acre tract; the balance was paid by the county. Contracts were let to Buckley Construction Co., St. Louis.

The proceeds from the sale were invested in U.S. Treasury notes from time to time during the period of construction and earned an interest of $25,714.60. Since the Hill-Burton funds, extended by Congress, were increased to $227,000, the board had sufficient funds to build a 130-bed home and voted to do so.

On Sept. 15, 1959, the project was sufficiently completed so that about 32 patients from Sunset Haven were transferred to the new Jackson County Nursing Home, and other patients have been admitted as facilities and trained personnel are available. Mr. George Rollo, former administrator of the Marshall Browning Hospital, DuQuoin, was employed as administrator early in 1959 to help the architect and board select furniture and furnishings.

At this writing there are approximately 125 patients. When the home is filled to capacity, there will be about 65 employees. It is believed that the nursing home not only will be self-sufficient for its operating cost but, over a period of 50 to 60 years, will be able to repay the cost of the building to the taxpayers of Jackson County. During the time the bonds are being paid, any excess over operating cost will be applied to paying off the bonds and will reduce the taxes to that extent.

The beautiful building on landscaped grounds, the wholesome atmosphere, and good medical services available reflect in the patients' faces. Many citizens seeing them are convinced that having the services of this nursing home is adequate compensation for the small increase in taxes. It is a testimonial to the desires of Jackson County people to furnish adequate medical care for the aged and infirm and is proof that local government with state and federal governmental help has, can, and will meet the needs of the citizens of this area.

Jackson County operates under a Board of Supervisors, and the nursing home was constructed under three chairman: Clyde Perschbacher, Mrs. Hallie Parrish, and Mrs. June T. Snider. Chairman of the nursing home committee for those three years was W. I. Brandon, present chairman of the board.

Under the rules and regulations adopted by the Board of Supervisors, patients who are residents of Jackson County are given preference, and no distinction is made between Illinois Public Aid patients and private patients. After residents of Jackson County, preference is given to IPAC recipients, then residents over nonresidents of the state. There is no discrimination based on race, color, or creed, and the cost is the same. However, the fees for doctors and the cost of drugs do vary according to the patient. It is hoped that in the near future the nursing home will have a good physical therapy program.

The present administrator, John E. Chapman, his staff, and the Board of Supervisors of Jackson County welcome visitors and will show facilities to others interested in a similar nursing home.

Social Planners and Oldsters

Clement G. Martin, M.D.,* *Chicago*

America's strength has stemmed from independence and self reliance. Any successful democracy must have these as its roots. The social planners, Karl Marx and his successors, have always thought it necessary to do away with these concepts of independence. The warfare between classes, which they proposed, is the necessary early step toward a central social state. If there is no warfare between classes, there is no need for a large bureaucratic governmental referee. The United States, which has lasted so long and so well, has always been distinguished by its lack of class and caste.

The social planners who want to push us toward bureaucratic regulation have often sought to create class concepts within America's social structure. Their current efforts are being directed, quite successfully, in the lines of special pleadings for the "older folks." We have been told that the needs of these people are different and greater than those under 65 and that this "class" must be given special consideration.

Facts on Needed Care

If we are to think logically about this problem, we must be armed with facts.

The health needs of the aging are of concern to all physicians, but they must not be viewed as distinct and different from the illnesses of the rest of the population. The many advances in medical science since the year 1900 must first be reviewed if we are to see the fallacy of the social planners' statements clearly. The top ten causes of death, in order, in 1900 were:[1] (1) influenza and pneumonia, (2) tuberculosis, (3) gastroenteritis, (4) heart disease, (5) strokes, (6) chronic nephritis, (7) accidents, (8) cancer, (9) diseases of early infancy, (10) diphtheria. It is not easy to compare this 1900 list with a current list, though some great changes have occurred. Item 10 accounted for 43 deaths per 100,000 in 1900 and no deaths in 1958. In 1958[1] only influenza and pneumonia remained in the top ten, but dropped from first to seventh place. In 1958 for the population as a whole, the first three causes of death are all chronic diseases—diseases of the heart, cancer, and strokes. These conditions account for three fourths of all deaths in the 65-plus age group. Their diseases are not greatly different from those incurred in the 45 to 64 age group. In this latter group, too, 70 per cent of all deaths are due to heart diseases, cancer, and strokes.

Another frequent concern of the aging is the spector of chronic illness. This is not as real a problem as it might seem on casual inspection. Between 3 and 5 per cent of the elderly are bed- or house-confined.[2] The rest are really quite healthy, although not always filled with abundant energy. Dr. Ethel Shanas of the University of Chicago found in a survey[3] that 17 of every 20 older persons said that during the four weeks prior to the interview they had had an illness. But, as Dr. Shanas continues, about two thirds of the people who were ill said the illness in no way interfered with their normal behavior. They were neither kept in the house, restricted in climbing stairs, confined to

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a wheel chair, nor kept in bed. Actually, in the same interviewed group, the persons 65 and over reported their health as good, often disregarding their illness.

The picture of the bed-confined oldster has been so vividly painted that the free air of facts must be let in to drive this mirage away. The most numerous needs of the elderly are cared for on an ambulatory basis or in their own homes, just as in other age groups. About 5 per cent of the 65-plus age group are institutionalized.[2] The older person spends twice as much time as a patient in a general hospital as does the younger age group.[2]

In summary, those in the 65-plus age group need more medical care than the younger population. The amount of medical care that they do need has been sharply defined by the figures presented here. There is no question that this is an added cost for their budget.

Facts on Costs

However, the added cost of medical care when one is 65-plus has many offsetting factors. Forty per cent of the people in this age group own hospitalization insurance, according to "The Economic Characteristics of the Aged" by Rita R. Campbell.[4] In addition to this ownership of insurance, one must take into account actual spending. The *Life* magazine survey[5] of spending patterns in 1955 and 1956 showed that the 65-plus group spent 9 per cent less than the average younger person: $1,146 per year as against $1,247. According to the survey, two costs had increased: Medical and personal care went up $8, and miscellaneous goods and services increased $3. Everything else declined. The biggest drop was automotive, which went down $40. Home furnishings and recreation each declined $13, and home operation, food, beverages, and tobacco each declined $16. Clothing declined $14. In general agreement with this are the statements in the "National Profile Study" by Wiggins and Schoeck.[6] They found 90 per cent of older persons in their sample in good or fair health, and medical needs were light; 92 per cent had no medical needs not being cared for; and financial reasons for lack of care were minor for the other 8 per cent. In Wiggins and Schoeck's study two thirds of the older persons had medical insurance.

We must realize that the economic needs of older persons must be met by methods consistent with the basic rights of individuals in our society. Basic to our society and to justice are the fundamental rights of a free person to life, property, and the means of livelihood. No rights whatever accrue to a class within our society, for such accrual involves discrimination and inequality under both moral and statutory law.

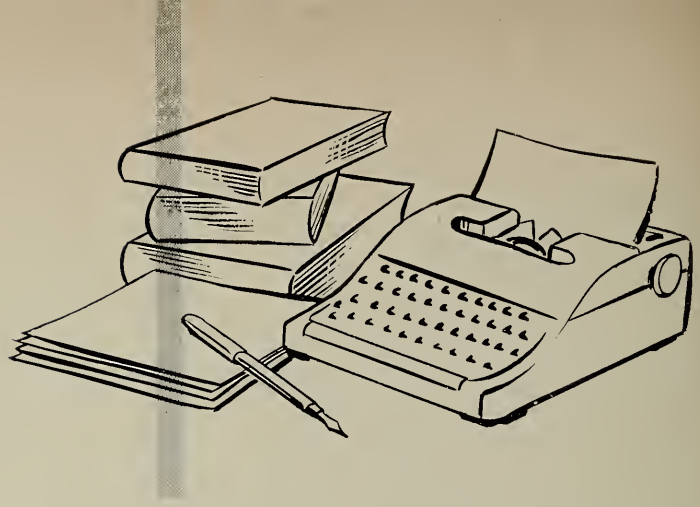
Medical aspects of health care of the aged currently in the forefront of research are cancer, arteriosclerosis, and heart disease. Scientific attacks are now being made upon these killers. Rehabilitation and restorative therapy are receiving increasingly more attention and are reducing the disabilities that were once the regular consequence of disease. Also, the economic burden of illness has been tremendously lessened because of the insurance industry's willingness to offer extremely valuable insurance to older persons.

Thus, in every way our parents and grandparents of today are more active, alert, and have greater justification for hope in the future than did their forebears.

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LITTLE PROGRESS can be made by merely attempting to repress what is evil; our great hope lies in developing what is good.—*Calvin Coolidge*



Editorials

Our Ways

The good physician thinks more of his family, integrity, health, religion, courage, and good name than of his materialist wealth. These are the true blessings that bring real enjoyment and satisfaction. A man can lose his tangible assets overnight, but courage and integrity bring lasting satisfaction and the ability to face the world with confidence.

The United States of America never will be conquered from without, but it could happen from within. The same can be said of medicine as it is practiced today. We must watch for that internal decay that begins in those who worship the golden calf and have grown complacent and lazy by feeding on the fatted calf. These people are willing to risk their neighbor's neck to preserve their own nest egg.

The holiday season gives us time for pause and self examination. It is up to each of us to set the example by establishing higher values of integrity and morality. Traditionally, this has been our way of life. We wish you a Merry Christmas and a Happy New Year.

Oral Poliovirus Vaccine Dosage

Pfizer's oral live poliovirus vaccine (Type I and Type II) is now available in frozen concentrates of 10 and 100 dose vials. The unit contains separate sterile, glass, rubber stopper dropper designed to deliver approximately 20 drops/ml. It must be stored at or below −4 F. (−20 C.). Type I and Type II vaccine must be administered separately and orally. It is fed by dropper or mixed with distilled water and consumed from a spoon or cup. It can be sweetened with a sugary syrup or placed on a sugar cube or cake for older children and adults. The dosage for children over six weeks and adults is 300,000 $TCID_{50}$ (Tissue Culture Infective Doses) or three (3) drops of diluted monovalent vaccine. A period of four to six weeks should be allowed between administration of Type I and Type II vaccine (eight weeks if Type II is used first).

There are no contraindications as yet, but the USPHS poliomyelitis advisory committee recommends that the oral vaccine be withheld for two weeks from persons who have undergone or are about to undergo tonsillectomy.

Overcharged Medical Bills

A young bank teller earning $6,500 per year underwent delicate skin-graft surgery. The surgeon sent him a bill for $1,500. The teller objected to the size of the bill and took it before the review committee of the local medical society. It reviewed all aspects of the case and recommended a fee of $600.

On the other hand, a committee described as a reasonable fee the $1,000 bill sent to an executive who receives $35,000 salary. He had a gallbladder operation.

Many state medical societies now have review committees, according to a survey conducted by Health Insurance Institute. Membership on the committees generally includes a cross section of the different specialties including general practice. They make recommendations regarding the reasonableness of fees regardless of the amount of insurance owned by the patient. Others are "empowered to consider and act upon all problems relating to the distribution, availability, and economics of medicine."

Medical care prices — including fees, hospital

rates, drugs, and insurance — have gone up 60 per cent since 1947-49. Many third-party groups are interested now in conserving their health dollar through a group of medical experts who review specific cases involving excessive fees by physicians, improper utilization of hospitals, and abuse of health insurance.

The medical profession is asked to deal with these problems because of discrepancies and inconsistencies. More and more employers are paying most or all of the health insurance premiums of their employees. For example, the recent national labor contract settlements in the steel and automobile industries direct companies to pay the full costs of employees' health insurance coverage. They set the pattern for other industries. The employers are interested obviously in cost and do not object to reasonable fees. Many are taking the bull by the horns and trying to educate employees, dependents, hospitals, and physicians on the necessity of conserving their health-care dollar.

It is difficult for some physicians to reduce cost because they are poorly organized and lack business acumen. It is easier to raise the fee and let it go at that. This creates a problem when the third party deals with hundreds or thousands of individual physicians, all with different economic skills and executive abilities. Furthermore, every case is an individual problem requiring different medical skills and time.

Dividend from Chicago

By way of a gift to our readers, so it happens, the JOURNAL brings to you this traditionally bountiful month, a new feature, "Anesthesia Conference" from Cook County Hospital. It will appear in the place of a Clinical-Surgical Conference every third month. These studies are being prepared by Dr. Vincent J. Collins, head of the department of anesthesiology at the hospital.

It will take up the medical problems that pertain to the outcome of surgery, for example, electrolyte balance, edema, coronary occlusion, and the effects of drugs.

Dr. Collins came to Chicago last spring from New York, where he was acting director of the department of anesthesiology at Bellevue Medical Center and a professor at New York University Medical College. He is chairman of the AMA Section on Anesthesiology, and has recently been appointed an associate professor at Northwestern.

We welcome Dr. Collins to our columns and trust that his contributions will be as stimulating and instructive as the Clinical-Surgical Conferences by his colleagues at Cook County, Drs. Robert J. Freeark and Robert J. Baker.

Resistant Staph Infections Controlled

Woodley and Hall confirmed previous reports on the efficiency of vancomycin (Vancocin®—Lilly) in the treatment of severe staphlococcal infections. They used this drug in 25 cases, including four with staphlococcal septicemia and two with acute staphlococcal endocarditis. There were eight cases of staphlococcal enterocolitis. Twenty of the 25 patients are living, and only three died because of uncontrolled infection. According to their article in the August issue of the *Annals of Internal Medicine*, vancomycin is the drug of choice in serious penicillin-resistant staphlococcal infections. Sensitivity studies before treatment demonstrated that the causative organisms were susceptible; specimens studied later showed that none developed resistance to the antibiotic.

The drug usually was administered intravenously, and the average dose was 1 Gm. every 12 hours. It was given orally in cases of enterocolitis in doses of 500 mg. every 6 hours.

Risks in the Pharmaceutical Industry

Twenty-five years ago Lederle Laboratories owned the world's largest rabbit warren. It housed the 28,000 rabbits from which Lederle was producing a new pneumonia serum. Pneumonia then was one of the most dreaded killers. Scientists had long sought a remedy. Lederle was the first to find it. A nation-wide distribution system was set up. The costly research program was about to pay off.

And it did—for 18 months. Then along came the sulfa drugs. They did the job better. The market for serum disappeared. Every dollar of the millions spent for this research had to be written off. From its serum making, Lederle derived "little except glory," former company president W. B. Bell said, "and the satisfaction of having saved countless thousands of lives."

This is typical of what can happen in the

prescription drug industry. It is a high-risk industry in which tremendous changes can occur overnight. As a result, company sales and earnings often show wide fluctuations from one year to the next.

In 1957 Schering, then a leader in the corticosteroid market, achieved record sales and earnings with its Meticorten and Meticortelone. Then three major competitors entered the field, and Schering's earnings dropped 23 per cent in the next two years.

Lakeside Laboratories set new sales and earnings records with its antispasmodics and diuretics until other companies introduced new products in the fields. In 1958 Lakeside earnings dropped 36 per cent. In 1959 the company reported a deficit of over $40,000.

Demand for a product can change, sometimes for no apparent reason. In 1958 nearly a quarter of the age group most susceptible to polio had not received any vaccine. Despite this fact, sales of polio vaccine dropped sharply. In consequence, Lilly shut down its polio vaccine plant for over three months. Its earnings fell 27 per cent in 1958 and continued to decline in 1959. Another important polio vaccine maker, Allied Laboratories (a division of the Dow Chemical Company), experienced a 46 per cent drop in earnings in 1958.

The decision *not* to market a drug can be costly. Smith Kline & French once developed a new product to prevent vomiting and to control psychosis. A hundred internists who tried to pronounced the new remedy "excellent." The company concluded, however, that it was not significantly better than others already on the market, and it was not completely free from the side effects of other similiar products.

With this decision, three-quarters of a million dollars in research and development funds went down the drain.

Research, lifeblood of a pharmaceutical company, is also its biggest gamble. The researcher never knows where his experiments will lead him, and the company never knows how commercially valuable the research will prove to be.

A recent survey showed that only one of every 3,000 substances investigated is likely to be found worth marketing. Many companies have sunk vast sums in projects that did not turn out. Lilly's long investigation of cortisone came to nothing, and the raw material was sold to another firm. Carbutamide, a sulfanilamide derivative for the treatment of diabetes, was another Lilly disappointment. Although carbutamide controlled many cases of diabetes, a 15-month clinical survey costing $850,000 turned up so many side effects that Lilly abandoned the product.

Since 1939 Lederle has invested a total of $7,500,000 in cancer research. In 1959 alone it invested $500,000. In that same year the total sales of its five anticancer drugs amounted to only $150,000.

Admittedly, when a new product lives up to expectations, rewards can be great. This is almost invariably the mark of a high-risk venture. It is the reason why South African gold-mining shares yield a higher return than 91-day Treasury bills. The history of profits in the pharmaceutical industry shows that what goes up can come down, often at dizzy speed.

Abbott Prescription Survey

The charges against drug companies by the Kefauver Subcommittee majority has had no effect on the prescribing habits of American physicians. According to David D. Stiles, director of market development at Abbott Laboratories, a study of the 1960 prescription market shows little change from 1959. Of the 410 most prescribed drugs, 344 were brand name products, three more than in 1959, and 66 were generic name products, two less than in 1959.

The average prescription price increased 1 per cent, from an average of $3.21 to $3.25.

The number of manufacturers represented among the top 344 brand names (products prescribed five times or more per 10,000 prescriptions) increased slightly from 56 to 63.

Stiles conducted the Abbott Continuous Prescription Survey, which shows that, over the past two years, the average longevity of products in the top 410 is six years. In 1960, 66 products, 60 of them brand name specialties, entered the top group, and 64 products dropped from the list.

He concluded in a release, "that competition continues vigorously and that the physician will prescribe in the best interests of his patient regardless of such controversies as those engendered through the Kefauver hearings and proposals."

The survey shows that the generic name products accounted for 10.3 per cent of all prescriptions filled, with 12 of the top 66 generic name drugs accounting for half of this total.

Does Money Attract Interns?

The major teaching hospitals are more successful than minor teaching and non-medical-school-affiliated hospitals in obtaining interns. In 1960 they were able to fill 83 per cent of their positions in contrast to 47 per cent and 22 per cent in the other types of hospitals respectively. Apparently they have something the medical graduates want that is lacking in those other institutions. Statistics from the National Internship Matching Program show that it is not the amount of stipend paid to the interns. Hospitals paying the smallest amount of stipend ($50 per month or less) with an annual average of approximately 80 per cent of positions filled are the most successful. Furthermore, the popularity of these hospitals has increased during the past eight years. Oddly enough the hospitals paying the most ($200 or more) fell from 61 per cent of the internship positions filled in 1953 to 38 per cent in 1960. These statistics show that it takes more than money to attract the intern. On the other hand, stipends may enter the picture when hospitals of the same type are being considered. But the non-medical-school-affiliated hospitals cannot expect to complete with the major or minor teaching hospitals by offering more money.

Epidemic of Warts

Plantar warts are on the increase in England, according to a *British Medical Journal* editorial. This conclusion was based on the observation that more and more patients are referred to hospitals for treatment despite the fact that warts seldom demand special attention. Furthermore, the increase appears to be real—not an illusion created by a free health service.

Some authorities are of the opinion that warts are spreading because England now has many more gymnasiums and facilities for swimming. Others found that the incidence of plantar warts in schools was directly related to the incidence of other warts.

There is controversy also about treatment and prevention. Those believing that the same agent is responsible for all warts are likely to treat plantar warts like the vulgar warts with therapy varying from suggestion to radical destruction. Antibiotics are of no value.

Those believing that gymnasiums are a factor have convinced many school authorities of the value of conducting "foot drills": inspecting the feet for plantar warts; persons with lesions are forbidden to use the pool. The inspection and preventive measures are similar to those conducted in the United States years ago for athlete's foot. They are based on the observation that plantar warts are more common in children approaching puberty and in people with a predisposition to moist feet. The need for dry soles is being stressed, and astringent lotions and foot powders are recommended. Time will tell whether the current epidemic of plantar warts in England will respond to these measures.

Occupational Headache

"Monday head" has nothing to do with drinking; it is an interesting occupational disorder that develops in those working with nitrates. It is a relative to the headache that occurs among victims of angina pectoris following the use of nitroglycerine.

McGuinness and Harris[1] recently reported three cases of nitrate head among chemists working with nitrates. All were comfortable over the week end but developed a severe throbbing headache after working several hours on Monday. The pain persisted until bedtime only to return on the following work day. The distress was associated with a sense of fullness in the head, palpitation, loss of appetite, nausea, faintness, tinnitus, mental confusion, flushing of the skin, and occasionally, visual disturbances. The headache was aggravated by stooping or lying down.

The route of entry was not certain, but inhalation was suspected because the chemists were exposed to nitrate dust and fumes. All recovered rapidly following the introduction of preventive measures in the laboratories.

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at the EDITOR'S DESK

Heart Hints

A follow-up of 447 patients by American Heart Association grantee Dr. Alvan Feinstein showed that children who came through the initial attack of rheumatic fever without heart damage were not likely to develop heart disease. There were 180 patients in this group, and among those who had recurrences none developed additional heart trouble.

The association also reported that death rates from heart attacks in middle-aged men are from 50 to 150 per cent higher among heavy cigarette smokers than among nonsmokers. The investigators suggest that nicotine stimulates the body's nervous system and the adrenal glands. In this respect, smoking had an effect comparable to emotional or psychic stress in triggering the increase in serum levels of cholesterol.

Pharmaceuticals

Armour's new tensitropic drug, Listica, is said to be so effective that it allays tension and anxiety in 89 per cent of the patients. In addition, it is so safe the patient may carry on all normal activities such as working, driving, reading, and writing. The claims are based on clinical studies of almost 1,800 cases. Less than four per cent reported side effects.

Kanumodic is Dorsey Laboratories' new triple-timed release tablet for treatment of the functional bowel syndrome. Each tablet contains pentobarbital, methscopolomine nitrate, cellulase, pepsin, glutamic acid hydrochloride, ox bile extract, and pancreatin.

Bronkometer is a pocket-size, ready-to-use aerosol containing isoetharine, phenylephrine, and thenyldiamine. It is manufactured by Breon Laboratories and said to be effective in severe asthma.

Wallace Laboratories is most optimistic about Capla, its new agent that may help prevent the development of hypertension. The rationale centers about their observation that the drug lowers blood pressure by a specific calming effect on overly active vasomotor centers in the brain. They are suggesting, in other words, that we calm our patients with Capla the moment the reading exceeds 140/90.

Cyproheptadine is a new drug possessing antihistamine and antiserotonin activity. It diminishes the skin sensitivity to pollen antigen and to histamine at least a hundred times. Clinical trials have been conducted on patients with asthma and hives.

Researchers of Eli Lilly and Company have greatly reduced the problem of febrile reactions to vaccines containing a pertussis component by extracting and using only the antigenic material from pertussis organisms. This method is utilized in Lilly's D-P-T (diphtheria and tetanus toxoids and pertussis vaccine combined) immunizing agent which is manufactured under the trade name of Tri-Solgen. The company claims fewer irritable and feverish babies, which means fewer calls from worried parents.

Cordran is Lilly's new corticosteroid topical preparation for pruritus and inflammation. According to tests by dermatologists, the new agent produced excellent or good results in 82 per cent of more than 1,600 cases treated. Sensitivity to the new product has not been reported.

Cordran comes in a cream or hydrophilic oint-

ment. It is available also in combination with neomycin sulfate (Cordran-N) for dermatoses complicated by skin infections.

Didrex, Upjohn's appetite suppressant, was used safely and effectively on a group of 60 obese patients with diabetes, high blood pressure, and many other cardiovascular disorders.

Foreign Physicians Ease Shortage

According to Newsweek, Americans may soon have to swallow a bitter dose of facts: The country doctor and his general practitioner counterpart in the cities are fast becoming extinct.

The number of graduates turned out by U.S. medical schools has remained constant over the past ten years, while the population has soared. And 80 per cent of the young physicians are now deciding to reap the higher salaries and shorter hours offered by specialist work, the report says.

Foreign physicians are helping to ease the shortage. For instance, 11 of Cleveland's 46 hospitals are entirely staffed by foreign physicians. But last year the American Medical Association insisted foreign physicians pass a language and medical qualifications test. Forty per cent failed, and two New York hospitals now may have to close down.

Third-Party Medical Care

The first comprehensive medical care program in the United States under the joint auspices of the New York Medical College, the New York Hotel Trades, and the Hotel Association of New York City was established recently. The program will represent an initial annual outlay of $290,000 by the Union Family Medical Fund of the Hotel Industry of New York, a joint labor-management body. The agreement, according to the medical school's News and Notes, will cover eventually 80,000 employees. Approximately 9,000 will obtain their medical care at the New York Medical College Flower and Fifth Avenue Hospital. The remainder will be covered by additional offices established throughout the city.

The union members will unquestionably obtain highly skilled care, but it has very little to do with the primary purpose of the medical school — to teach medical students.

Life-saving Procedure

Dr. Kurt O. Leonhardt saved five moribund patients, three in status asthmaticus and two with pulmonary emphysema. All were expected to die within a matter of minutes. They were either unconscious or semicomatose, with severe cyanosis and in marked hypoventilation.

Leonhardt relied on a mechanical means of treatment involving resuscitation and removing viscid mucus from the bronchi. A bag and bellows was used to ventilate two of the cases. In the other three cases, a bellows-type Kreiselman resuscitator was used.

An endotracheal tube was then inserted by the nasal route and suction applied, alternating rapidly with ventilation. In addition, theophylline ethylenediamine, hydrocortisone, and epinephrine were administered. The results demonstrated that a purely mechanical problem is involved in the terminal phase of bronchial asthma and emphysema.

To Recognize a Quack

The department of investigation of the American Medical Association has evolved six simple rules for spotting a quack. They are:

1. He uses a special or "secret" machine or formula he claims can cure disease.
2. He guarantees a quick cure.
3. He advertises or uses case histories and testimonials to promote his cure.
4. He clamors constantly for medical investigation and recognition.
5. He claims medical men are persecuting him or are afraid of his competition.
6. He tells you that surgery or x-rays or drugs will cause more harm than good.

Baby Care on Records

During the past decade there has been an increasing number of long-playing medical records of educational value to the layman. "Your Baby and You" is one of the latest. The album contains three 12″ long-playing records and is produced by Children's Institute, Inc., of Chicago. Dr. Ralph H. Kunstadter of Michael

Reese Hospital, Chicago, was the advisor and consultant on the project.

Your editor has heard the recordings which consist of a dialogue between doctor and nurse discussing various phases of baby care. It is presented as though the mother were sitting in the office of her physician. The records are well done, but, in my opinion, once heard are likely to be set aside. It might be better for the physician to have a set or two that could be loaned out to new and expectant mothers.

Who Gets Tanned?

Miami's plush Bal Harbour Hotel has been converted into a medical clinic catering to top corporation executives, according to John J. Mann, a Detroit auto dealer and president of the new company, Bal Harbour Diagnostic Service, Inc. Dr. Morris Fishbein will head the clinic's advisory board.

Set to open December 1, the clinic was designed to appeal to executives of major corporations, high salaried employees, and airline pilots who want complete, periodic medical examinations. Plans also call for the clinic to sponsor frequent seminars of top physicians.

The clinic will have a staff of local physicians, many from the University of Miami School of Medicine. Twenty of the 191 rooms were converted into laboratories and other medical facilities, with the remaining ones for the patients.

Don't forget your Man-Tan, boys!

Quickies

The noise made by scraping a saucepan with a knife is the worst known to man, according to a report in Health Education Service. Anything worse will make us howl.

Delegates to McCall's Congress on Better Living feel that doctors and dentists who cater to their patients and make the surroundings more attractive win the favor of women. One delegate told of a very popular children's dentist in her home town. "He and his assistants all wear cowboy clothes, and the children sit on a wooden horse instead of a chair."

The nation's cleanest air, according to *Patterns of Disease,* is to be found over deserts.

Eating sweets between meals is much more likely to cause tooth decay than eating the same quantity of sweets at mealtime, according to dentists from the University of Rochester Medical Center.

From the Albany Medical Center we learn that the death rate from coronary heart disease is three times greater in middle and older aged men who are heavy cigarette smokers than it is in a comparable group of nonsmokers, pipe and cigar smokers, and former cigarette smokers.

The American Cancer Society estimates that about 173,000 people in the United States will be saved from cancer in 1962 — 3,000 more than in 1961.

Another Automatic Toothbrush

The new automatic toothbrush of General Electric consists of a power handle containing a battery. It is not attached to an electric cord but is stored in a recharger holder when not in use. It should appeal to the flabby generation who could, but seldom do, as good a job by hand. Tests show that the special action of automatic toothbrushes reaches and cleans all surfaces, including deep fissures and interproximal regions.

Hypersensitive Teeth

Strontium chloride in tooth paste controls hypersensitivity of the teeth. According to Dr. Abram Cohen of the University of Pennsylvania, the element reduces the pain in the teeth caused by heat, cold, acids, sweets, and even touch, within a few days. The dentifrice will be known as Sensodyne. We have no idea what will happen when Cohen's strontium mixes with Khrushchev's radioactive variety, but we can assume that the pain will not come from the teeth.

Disposable Diapers for Newborn

The disposable diaper (CHUX) developed by Johnson and Johnson is chemically sterilized and guaranteed to remain sterile until the

package is opened at the cribside. It is said to be timesaving and economical for hospitals, eliminating laundering, sterilizing, folding, and replacement costs of cloth diapers.

These are the same advantages obtained through a commercial diaper service, but Johnson and Johnson claim that the cost of the disposable diaper is no greater. Besides, the incidence of irritation and infant rashes caused by the effects of harsh caustic laundry soaps is lessened.

A package of CHUX contains a dozen diapers, placed so that the nurse can remove them without touching the facing. The diaper is lined with Sofnet fabric containing bleached, absorbent cellulose. An embossed polyethylene backing serves as an effective moisture barrier and a firm anchor for pinning.

Psychopathic Turnover

The number of Veterans Administration mental patients recovering and leaving the hospital each year has nearly tripled during the last eight years. As a result, the VA hospitals with the same number of beds are able to treat many more psychiatric patients.

Blue Shield Members

More than 48,150,000 persons were enrolled in the 75 Blue Shield Plans located in North America as of June 30, 1961, the National Association of Blue Shield Plans announced. Total membership in Blue Shield Plans at the end of June reached 48,154,563, as a result of a net gain of 201,558 new members during the second quarter of 1961.

Who Retires at 62?

Secretary Abraham Ribicoff announced recently that the results of a four-week tally of claims for social security benefits indicate that most men who apply for reduced benefits before age 65 are retired or out of a job. Most of the employed men were in the low-paid or part-time jobs, and only two per cent would have to quit work or reduce their earnings in order to begin collecting social security benefits.

It is not popular nowadays to look ahead or project into the future, but we already have some justification for raising the benefits for those who choose to receive their social security before age 65. There are lots of votes in this group, especially when they didn't choose but were forced through unemployment or sickness to accept reduced benefits.

Glial Damage

A government study conducted at the University of California demonstrated that the earliest effects of alpha radiation on the brain of rats was to the brain tissue rather than to the blood vessels as previously thought. The rats were irradiated with alpha particles from a 60-inch cyclotron, and disturbances in the permeability of the blood vessels in the brain were observed 48 hours after irradiation.

But investigators found glycogen granules in the glial cells within 24 hours after the animals were exposed. The study also utilized a new technique involving the labeling of albumen with fluorescein which made it possible to detect the penetration of proteins through the walls of the blood vessels. Apparently the radiation injury disrupts the protein bonds of glycogen resulting in its liberation through the blood vessels and subsequent uptake by the glial cells.

High on the Dog

One of our friends who has lately acquired a collie-beagle puppy took him to the veterinarian for shots. The charges for immunization were as follows: $10 for distemper shots; $6 for two hepatitis shots; $12 for two leptospirosis shots; and $5 for a once-a-year rabies shot. The grand total is $33.

Well, it probably costs more to immunize your dog than your child. If so, it's a "shot-in-the-arm" for physicians.

No Tickee

A speeding charge against a woman was dismissed in Wokingham, England, recently when she testified that she was rushing her pregnant Pekinese dog to a veterinarian. [Reuters]



Official Business

Members Oppose Social Security Coverage

To Paraphrase Alfred Marshall, the famous British economist who wrote many years ago, there is nothing more dangerous than facts left to speak for themselves. The recent poll of Illinois physicians was directed by the 1961 House of Delegates to determine whether members of the Illinois State Medical Society want to be covered under the OASI (Old Age and Survivors Insurance) provisions of the Social Security Act.

In keeping with the directive of the House of Delegates, county societies were given the option of conducting their own poll or accepting the results of the poll mailed directly from Society headquarters. Five county societies, Henry, Mason, Peoria, Pike and Tazewell, elected this option.

To help clarify the issue of social security coverage for physicians, a one-page summary of the advantages and disadvantages accompanied the ballots mailed to members September 27. Ballots were coded by county. Results were tabulated at the State Society office with the exception of Tazewell and Peoria counties. These ballots were tabulated locally, and the results were transmitted to the State Society by telephone. They are included in the analysis that follows.

The ballot consisted of four questions: (1) Are you now covered by Social Security? (2) If you are now covered by Social Security, do you wish to remain so? (3) Are you in favor of compulsory Social Security coverage for all physicians? (4) Your age?

The results of the poll clearly indicate that the *majority of responding members are opposed* to compulsory coverage for physicians under OASI provisions of the Social Security Act (question 3). Sixty per cent of the total membership (6,132) responded to the key question, representing over 66 per cent response of the downstate members and 56 per cent of the Cook County members. Of the total vote cast, over 54 per cent opposed compulsory coverage. When the 1,303 physicians presently covered by social security are excluded from the total vote on question 3, the percentage of those opposed to compulsory coverage is still 54 per cent. Thus, the votes of those now covered by social security did not change the results for the state as a whole.

Of the already covered downstate physicians, 68 per cent oppose compulsory coverage for all physicians. Only 50 per cent oppose it in Cook County where about three-fifths of the vote lay.

Table 1 summarizes the results by age groups for the whole state. Physicians under 55 and those over 75 years of age oppose compulsory coverage. Between these are the two age groups (55-74) who favor coverage by a margin of 54 to 46. In the whole state 16 per cent of the physicians now covered do not wish to remain covered.

Table 2 summarizes the results in the two sections, Cook County and downstate, by age groups. Sixty-three per cent of downstate members oppose coverage. By contrast, 48 per cent of Cook County members oppose compulsory coverage. It is interesting to note that in each age group downstate a majority of physicians oppose compulsory coverage. However, in Cook County those physicians under 45 and those over 75 as a group oppose it, 56 to 44 on a percentage basis. This leaves the age groups

Table 1—Results of Social Security Poll, State of Illinois by Age, Nov. 10, 1961

Age	Question 1 Are you now covered by social security?		Question 2 If you are now covered by social security, do you wish to remain so?		Question 3 Are you in favor of compulsory social security coverage for all physicians?	
	Yes	No	Yes	No	Yes	No
Under 35	134	322	79	48	103	357
35-44	411	1,287	310	84	723	1,041
45-54	406	1,381	344	40	885	919
55-64	262	894	211	28	643	519
65-74	139	455	117	11	307	284
75 and over	40	183	36	1	87	132
No age	29	88	20	4	61	71
Total	1,421	4,610	1,117	216	2,809	3,323

Table 2—Results of Social Security Poll, Summary Totals, Nov. 10, 1961

Age	Question 1 Are you now covered by social security?		Question 2 If you are now covered by social security, do you wish to remain so?		Question 3 Are you in favor of compulsory social security coverage for all physicians?	
	Yes	No	Yes	No	Yes	No
Cook County						
Under 35	92	156	55	32	74	178
35-44	245	681	194	46	455	488
45-54	250	793	223	14	579	476
55-64	167	551	145	11	437	282
65-74	100	299	84	8	220	179
75 and over	18	92	15	0	46	59
No age	17	49	13	2	41	37
Total	889	2,621	729	113	1,852	1,699
Downstate						
Under 35	42	166	24	16	29	179
35-44	166	606	116	38	268	553
45-54	156	588	121	26	306	443
55-64	95	343	66	17	206	237
65-74	39	156	33	3	87	105
75 and over	22	91	21	1	41	73
No age	12	39	7	2	20	34
Total	532	1,989	388	103	957	1,624

45 to 74 in favor of coverage. These data refute the allegation that the younger physicians favor social security, both in Cook and downstate.

The ballot took cognizance of those physicians already covered by social security in whole or in part (question 1), for example, those in industrial or organized groups, and sought their opinion on continued coverage (question 2).

Results from question 1 show that roughly the same proportion of physicians in Cook County and downstate are already covered, 25 per cent and 21 per cent respectively. Most physicians in this category downstate favor continued coverage—8 out of 10; in Cook County the proportion is about 9 out of 10.

An analysis of the vote by county shows 72 of the 90 downstate counties oppose coverage.

Table 3—Results of Social Security Poll by County Nov. 10, 1961*

Downstate Counties	Are you in favor of compulsory social security coverage for all physicians? Yes	No
Adams	22	23
Boone	6	5
Bureau	12	13
Carroll	6	7
Champaign	33	72
Christian	6	10
Coles-Cumberland	11	23
Crawford	5	5
DeKalb	9	19
Douglas	0	10
DuPage	50	85
Effingham	2	15
Ford	4	7
Franklin	8	10
Fulton	8	7
Henry	9	8
Iroquois	4	13
Jackson	12	20
Jefferson-Hamilton	3	9
Kane	52	86
Kankakee	18	24
Knox	33	15
Lake	83	83
LaSalle	21	42
Lee	5	12
Livingston	7	13
Logan	6	13
Macon	33	56
Macoupin	4	13
Madison	32	44
Marion	9	10
Mason	2	9
McDonough	3	14
McHenry	10	18
McLean	11	55
Morgan	7	14
Ogle	4	12
Peoria	56	139
Randolph	4	6
Richland	5	9
Rock Island	31	46
St. Clair	29	66
Saline	4	8
Sangamon	43	65
Stephenson	12	10
Tazewell	15	22
Vermilion	16	45
Whiteside	19	16
Will-Grundy	50	45
Winnebago	50	104

*To preserve anonymity, county results are not indicated when the total of ballots received was less than 10.

Of the remaining 18 counties, 13 favor coverage and 5 have a divided vote.

The response was good. Over 6,000 of the 10,000 ballots mailed were returned.

In summary, the results support the statement that a majority of physicians responding to the State Society's poll clearly oppose coverage under OASI provisions of the Social Security Act. This is the basic conclusion. Specifically, 3,323 of those physicians voting (54%) indicated their opposition to coverage.

Committee on Medical Economics
John R. Wolff, M.D., *Chairman*

Society Action on AMIA Program

The following letter from Dr. Edwin S. Hamilton, president of the ISMS, was sent November 7 to members of the House of Delegates, the Council, and County Society Secretaries.

To advise you of the action taken as a result of the special meeting of the House of Delegates, we enclose a copy of our letter to Mr. C. Virgil Martin, chairman, Illinois Public Aid Commission. The Reference Committee Report containing the resolution as passed by the House of Delegates appears on pages 7-8 of the November Illinois Medical Journal.

Since this program must be evaluated after a six-month trial period, we ask that each county medical society accept the responsibility of closely following and reporting developments on the local level. Significant problems encountered locally should be transmitted promptly to the State Society Ad Hoc Committee. We look forward to a flow of information from each county society, sufficient to provide the Ad Hoc Committee with an appraisal of the effectiveness of the AMIA [Aid to the Medically Indigent] program in meeting the needs

of the aged in each local area.

November 2, 1961

Dear Mr. Martin:

I am pleased to report to you at this time on the actions of the House of Delegates of the Illinois State Medical Society regarding the Aid to the Medically Indigent Aged program. The special meeting of the House of Delegates was held in Chicago, October 28-29.

The enclosed reference committee report, adopted unanimously by the House of Delegates, sets forth the official position of the Society. We believe the report is clear in expressing the desire of the physicians to cooperate in the AMIA program under the existing revised rules for a trial period of six months. It also clearly expresses the desire of the physicians to have certain additional improvements made in the program at the earliest opportunity.

We are prepared to meet with members of the commission anytime you may desire for further discussion of this program. Since we wish to aid in the successful operation of the AMIA program by making an evaluation at the end of six months, we would be pleased to receive periodic reports as they become available.

Sincerely yours,
Illinois State Medical Society
Edwin S. Hamilton, M.D., *President*

Second Councilor District Meeting

On November 2, Dr. Ralph N. Redmond hosted an afternoon and dinner meeting of the Second Councilor District at the Kaskaskia Hotel, La Salle.

At the afternoon session Dr. William McNichols, Lee County Society delegate, in his report on the special session of the House of Delegates said he was pleased to see that all delegates had adequate time on the floor to discuss the varied problems the Kerr-Mills program presents to physicians.

Dr. Dexter Nelson, secretary of the Bureau County Medical Society, reported on the Secretaries' Conference held October 8.

Mr. Robert L. Richards and staff of the ISMS conducted a panel discussion on "Current Activities of the Illinois State Medical Society." Included was a sneak preview of ISMS's new TV series that will soon be seen over Illinois stations. The pilot film, featuring Burgess Meredith, dramatically describes the advantages of every family having a family physician.

Mrs. Richard Westland, president of the Woman's Auxiliary to ISMS, spoke on "How the Auxiliary Can Help."

The after-dinner speaker was Dr. E. A. Piszczek, chairman of the Council of ISMS. He related some of his observations of the deplorable conditions in government controlled hospitals and clinics in Europe last year. More doctors should make every effort to visit these European countries.

Capable of Love Dr. Mehlman defines the "psychologically healthy" individual as "one who is capable of love," a love involving a specific manner of relating to others which, in turn, involves "taking from them without draining or depleting them and giving to others without overwhelming or obligating them." The individual capable of this type of love, says Dr. Mehlman, has these characteristics: respect for self and others; responsibility; the ability to be alone; can see and accept himself as he really is. Then he can love and in love he can see himself and others in fullest measure. *Benjamin Mehlman, Ph.D. Love as the Measure of Man. Mental Hygiene. January 1961.*

Book Reviews



THE HAND, A MANUAL AND ATLAS FOR THE GENERAL SURGEON. Henry C. Marble, M.D. $7. Pp. 207. Philadelphia, W. B. Saunders Company, 1960.

As stated in the preface, this book is a summary of the author's personal experiences and practices in surgery of the hand, and that in itself usually adds to the value of a book. The illustrations throughout the book are clear-cut, easy-to-follow drawings by Mildred Codding, a superb medical artist. The drawings of specific muscles of the hand and forearm on one page and their functions on the facing page are more helpful than pages of words. In the section on anatomy the relations of the involved structures are shown by multiple cross sections, a method of illustration extremely valuable in regions where the arrangement of structures is so complex. The chapter on applied physiology will remind the reader of a number of points not ordinarily considered to be related to the hand. Whether these matters will be of help to those who care for the hand on the day of injury, a goal expressed in the preface, is debatable.

More space could be devoted to the history. In addition to the more common circumstances leading to injury of the hand, the time elapsing since trauma, the details of any first-aid rendered — including attempts to "catch bleeders" or any other manipulation in the depths of the wound — should be determined. Fractures of the elbow, forearm, and wrist are included in the chapter on closed injuries. The inclusion of injuries of the upper extremity at these levels may be unusual in a book entitled "The Hand," but the effect of trauma to these regions upon the function of the hand is, of course, obvious. More emphasis on the many types of injury involving the metacarpals and phalanges and their management would be helpful and appropriate for a treatise on hand injuries.

Little mention is made of general anesthesia. Regional anesthesia as recommended by the author is highly desirable under certain circumstances. However, it is not as readily available in most hospitals as is general anesthesia. It is not suitable for children, as a rule, nor in fact, for a large proportion of adults with hand injuries. It is often considered the only safe anesthetic for a patient who has recently eaten. However the stomach can usually be emptied adequately by lavage through a large tube. General anesthesia can then be used just as in the fasting patient. When used only occasionally, regional anesthesia may be only partially successful or may wear off during the course of a prolonged procedure which the repair of an injured hand often becomes. A blood pressure cuff used as a tourniquet on the upper arm is the usual way of attaining a bloodless field so necessary for either emergency or elective surgery of the hand. If regional anesthesia is used, it must include the upper arm to enable the patient to tolerate the inflated blood pressure cuff. The author uses a "ring" of local anesthesia injected subcutaneously to attain this end.

The author indicates that the application and subsequent management of the blood pressure cuff as a tourniquet is highly important as he does this himself rather than delegate it to some other member of the team. The author recommends that after elevating the arm for four minutes, the blood pressure cuff should be quickly inflated to 300 mm. Hg. Clamps are then placed on the tubes leading from the cuff to the bulb and the gauge. A bloodless field can

be attained by a cuff pressure which exceeds the patient's systolic pressure by 20 or 30 mm. Hg. Pressures beyond these levels cause unnecessary and excessive compression of the surrounding structures, the most vulnerable being the radial, median, and ulnar nerves. Placing clamps on the tubings prevents the gauge from registering the pressure in the cuff, and the surgeon will be unaware of changes in cuff pressure.

After anesthesia is established and while cleansing the hand for repair, one has the best opportunity to assess the structural damage. At this time the findings can be recorded diagrammatically on a chart, and careful notes describing details should be dictated as the cleansing progresses and the deeper portions of the wound are exposed.

While it is agreed that "for the record" it is essential to measure the range of motion of the joints in the hand as determined by an arthrometer (and described so well in Chapter III), it is the ability of the hand to perform which counts in the long run. For this reason it seems reasonable to suggest that the ability to grasp small objects, button one's shirt, tie a tie, and resume the activities previously performed by the injured hand forms a realistic basis for evaluation of injuries and results of treatment.

The book does not present a plan for the after-care and rehabilitation of the injured hand. A few pages devoted to such matters as when one discards a splint, when to begin passive or active motion, and the various means by which restoration of normal function can be accomplished would be appropriate.

The material concerning accidental amputations of the digits presents the management of those that reach the level of the distal phalanx and expose bone and includes skin grafting of the exposed end. Many accidental amputations with lesser soft tissue loss and no bone defect may heal well without grafting. The use of drains was not mentioned in the author's management of the injured hand. Many surgeons believe that a drain properly placed and arranged so that it can be removed without disturbing the dressing will allow the escape of serum which would otherwise interfere with satisfactory healing.

The consideration of infections presents the fundamentals adequately in proportion to the whole. The chapter on tumors is short but concise as befits such presentation in a book largely devoted to trauma.

The author's personal experiences qualify him to speak with authority. He has presented the details of the management of hand injuries which he has found to be most successful. This volume should be of interest and help to all surgeons caring for such injuries, particularly those who have not had experience in this most exacting field of surgery as part of their surgical training.

John L. Keeley, M.D.

A Prelude to Medical History. Felix Marti-Ibanez, M.D. $5.75. Pp. 253. New York, MD Publications, Inc., 1961.

Written primarily to stimulate medical students to become better physicians, this book covers the history of medicine in eight well-composed chapters. It begins with a definition of medicine, describes paleomedicine, outlines the principle features of primitive medicine, delineates the contributions of Mesopotamia and Egypt, discusses the philosophers and physicians of classical Greece and Imperial Rome, tells the story of the Byzantine and Medieval periods, and traces the role of medicine from the Renaissance to the present.

The Epilogue entitled "To Be A Doctor" emphasizes the moral, ethical, and social responsibility of the physician and urges them to serve mankind in the fullest measure at the bedside, laboratory, and podium. A brief chapter follows on recommended reading with a section on Nobel prize laureates and a final section on chronology, as well as a useful index. There is little mention of the contributions of the ancient Hebrews, Chinese, Japanese, and natives of India. The author writes with a warm flowing style and excellent diction, introducing numerous anecdotes and valuable quotations from medical sources. He places the doctor in his historical setting and emphasizes his role in relation to other knowledge. Marti-Ibanez not only succeeds in conveying his enthusiasm as a teacher of medical history but imbues his reader with the grandeur of the whole course of medicine.

Frederick Stenn, M.D.



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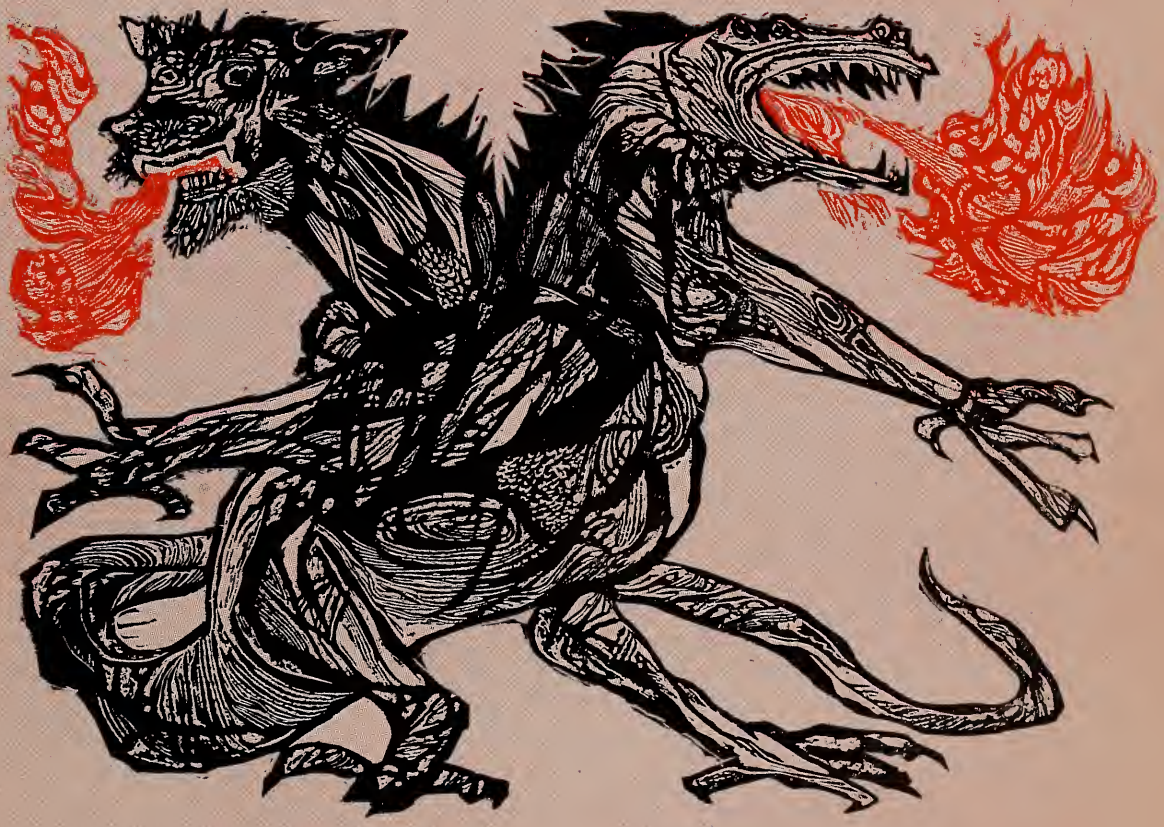
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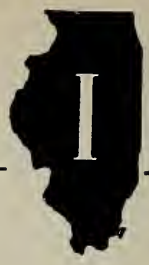
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NEWS of the STATE



Adams County

Dr. Swanberg Honored

Dr. Harold Swanberg, Quincy, was honored at the annual meeting of the American Medical Writers' Association in New York, when it voted unanimously to rename its yearly top award the Harold Swanberg Distinguished Service Award. Dr. Swanberg is a founder and for many years was secretary-treasurer of the association.

By mutual agreement the association severed its connections with the Swanberg Collegiate Educational Fund, a collegiate scholarship and fellowship program of which Dr. Swanberg is secretary-treasurer.

Cook County

Dr. Meyer Has His Day

October 25 was KAM Day in Chicago, so designated by Gov. Kerner and Mayor Daley in honor of Dr. Karl A. Meyer, Chicago surgeon and director of the Cook County Medical Institutions for 45 years. The day of special activities was capped with a dinner for Dr. Meyer attended by more than 1,000 friends and business and civic leaders. Funds from the $50 a plate banquet went to his favorite charity, the Chicago Foundlings Home, where he is president of the board.

A leading figure in Chicago medicine, Dr. Meyer is chief surgeon at Columbus Hospital and president of the board of Cook County Graduate School of Medicine. He also is a former president of the Chicago Medical Society. A 1908 graduate of the University of Illinois College of Medicine, he was chief surgeon at County Hospital for a number of years and was the youngest man ever to be medical superintendent there. In addition, he has been a trustee of the University of Illinois and a member of the West Side Medical Center Commission.

Dr. Foa Cited by Technical Societies

Dr. Piero P. Foa, professor of physiology and pharmacology at the Chicago Medical School, has been cited by the Chicago Technical Societies Council for its 1961 Merit Award. The award is given annually to distinguished scientists in the Chicago area on the basis of their scientific and technical achievements and their contributions to civic betterment.

He has lectured and written extensively on research studies into the physiology and chemistry of glucagon and on factors affecting diabetes and human metabolism.

Mead Johnson Award to Dr. Roberts

Dr. Stuart S. Roberts, Oak Park, a senior resident in surgery at University of Illinois Hospitals, has received the Mead Johnson Graduate Training in Surgery Award of $3,000 a year for three years. He plans to spend the next two years doing cancer research at Memorial Hospital for Cancer and Allied Diseases, New York.

In 1958 he received the Gold Award for Scientific Exhibit from the Illinois State Medical Society.

St. Francis to Have Guidance Center

St. Francis Hospital, Evanston, will open an Adult and Child Guidance Center in January, 1962, with Dr. Robert M. Zirpoli, head of the Child and Adult Psychiatric Clinic at Mercy Hospital, as director. The center will provide

(continued on page 42)

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State News *(continued from page 40)*
outpatient psychiatric facilities for diagnosis and treatment, assist in developing and maintaining community health standards, and supplement present medical, educational, and research facilities at St. Francis.

U. of C. Has New Department Head

Dr. Leon O. Jacobson, Chicago, professor of medicine of the University of Chicago, has been made chairman of the department of medicine after serving as acting chairman for the past seven months. He also is head of the Argonne Cancer Research Hospital, operated by the university for the U.S. Atomic Energy Commission.

Elections

Dr. Edward J. Krol, Chicago, was chosen president-elect of the American College of Gastroenterology at the annual meeting of the college in October.

Dr. Kroll is clinical instructor of surgery, Loyola University's Stritch School of Medicine; co-chairman of the department of surgery, Holy Cross Hospital, and vice-chairman of the section on general surgery of the American Medical Association.

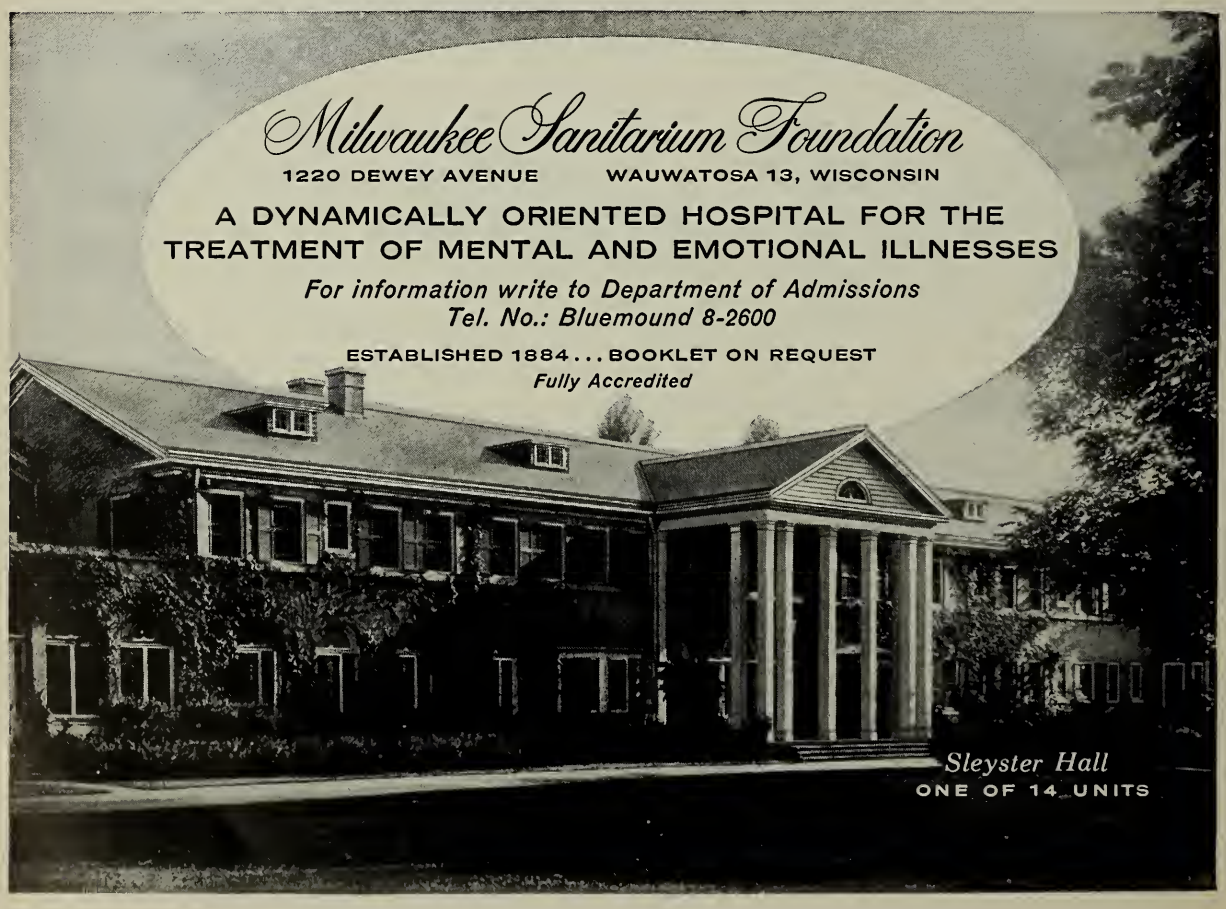
Dr. Earl E. Barth, Chicago, professor and chairman of the department of radiology at Northwestern University Medical School, was recently chosen president-elect of the American Roentgen Ray Society. Dr. Barth just completed a year as president of the American College of Radiology.

The 1961-62 officers of the Chicago Rheumatism Society are Drs. Edwin Passarelli, president; Frank R. Schmid, vice-president; and James F. Kurtz, secretary-treasurer.

Appointments

Albert V. Crewe, Ph.D., a division director at Argonne since September, 1958, will succeed Norman Hilberry as the director of the Argonne National Laboratory. Argonne, one of the

(continued on page 45)



world's leading "atoms for peace" research centers, is operated by the University of Chicago for the U.S. Atomic Energy Commission.

Hilberry, 62, director of the laboratory since 1956, had suggested some time ago that his successor be appointed well before his retirement.

Dr. Paul C. Bucy, professor of surgery, Northwestern University Medical School, Chicago, has been appointed to the National Neurological Diseases and Blindness Council for a four-year period. He is an internationally known brain surgeon with broad experience in the general field of neurologic research.

The 12-member council serves in an advisory capacity to the Surgeon General and the National Institute of Neurological Diseases and Blindness in the awarding of grants for research in the neurologic field.

Dr. Robert B. Lawson, chairman of pediatrics and acting dean of the University of Miami School of Medicine, will succeed Dr. John A. Bigler as chief of staff of Children's Memorial Hospital on February 1 when the latter retires. Dr. Bigler will remain on the hospital's staff as consulting pediatrician.

Dr. Lawson organized the pediatrics department of the Bowman Gray School of Medicine at Wake Forest College, N.C., and is on the editorial board of the American Journal of Diseases of Children.

Other new faculty appointments and promotions at Northwestern are: Dr. Roland P. Mackay, from chairman of the department of neurology at Presbyterian-St. Luke's Hospital to professor of neurology and psychiatry; Dr. Vincent J. Collins, director of anesthesiology at Cook County Hospital, is associate professor in surgery.

Illinois Pediatrics Consultant Appointee

Dr. J. Keller Mack, Springfield, has been appointed consultant in pediatrics for the division of children's services, Illinois Department of Mental Health.

(Continued on page 46)

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Grants

Presbyterian-St. Luke's Hospital has received a $157,881 grant from the Department of Public Health and Welfare to study the effects of certain types of fats on blood coagulation.

Director of the project is Dr. John H. Olwin, Evanston, a member of the attending staff at Presbyterian-St. Luke's; co-director is J. L. Koppel, Ph.D., also a member of the hospital staff.

Northwestern University Medical School has been awarded a grant of $44,000 for two years to take part in a nationwide program to study high blood pressure caused by kidney disease. The school is one of eight major U.S. research institutions who will participate.

It will be the first time the disease has been attacked on an organized nationwide basis and will involve nearly 50 physicians throughout the U.S.

The National Heart Institute of the National Institutes of Health is the sponsor. The University of Illinois is also a participating institution.

Other national institutes of Health grants: John E. Jacobs, Ph.D., professor of electrical engineering at Northwestern's Technological Institute, received $37,145 for research on development of a system for visualizing the transmission of high frequency sound waves through the body as a means of medical diagnosis.

Dr. Richard E. Trueheart, assistant professor of pathology and pathologist at Evanston Hospital, received $20,010 for the study of the role of the thyroid gland in certain kinds of cancer.

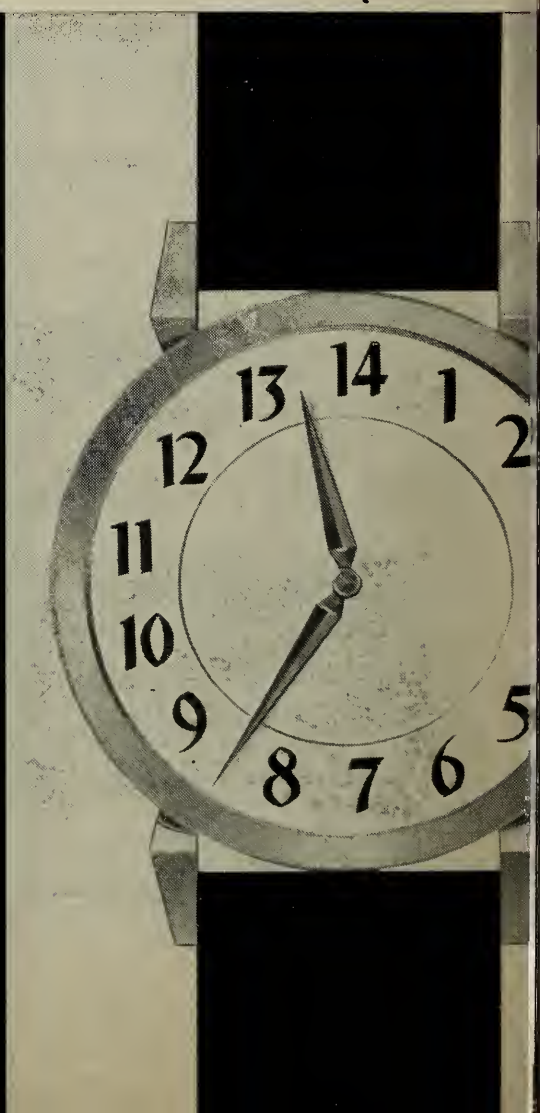
Dr. Herbert Rattner, professor and chairman of dermatology, received $18,662 for studies of human skin cancers.

Dr. John T. Grayhack, chairman of the department of urology, received $7,705 for investigation of the role of hormones in prostatic growth.

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McDonough County

The McDonough County Medical Society elected the following officers for the 1962 term: Drs. Kenneth T. Pawlias, president; Bruce H. Borum, first vice-president; Budris Andernovics, second vice-president; and Charles L. Weston, secretary.

St. Clair County

The St. Clair Medical Society has announced its officers for the new year: Dr. Harold McCann, president-elect; Dr. William Knaus, vice-president; Dr. Theodore Bryan, secretary; and Dr. James Crilly, treasurer.

Tazewell County

Small Town Points the Way

Hopedale, population 500, has marked the successful completion of a "do-it-yourself" project started over six years ago.

"Hopedale Complex" — a hospital, nursing home, retirement apartments, and nurses' residence — had its origin in the town's effort to keep its physician. In 1953 Dr. Lawrence Rossi was planning to close his office in Hopedale because of the difficulty in calling on patients scattered throughout the county and the lack of nearby hospital facilities. At the suggestion of the physician, local business and religious leaders got behind the idea of a small general hospital for the community. A series of community meetings and a fund drive raised $75,000 for this purpose by early 1954. Additional pledges of funds and labor raised resources to the needed $175,000, and the 20-bed completely equipped Hopedale Hospital was opened in May 1955.

The 40-bed Hopedale Nursing Home, opened in December, 1958, was built as an answer to the needs of many chronically ill patients who were occupying beds in the hospital.

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liver or other clinical toxicity after up to ½ years of daily use of DBI-TD early 5 years with the DBI tablet)

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administration and dosage: One 50 mg. DBI-TD capsule with breakfast regulates many stable adult diabetics. If higher dosages are needed, after one week a second DBI-TD capsule is added to the evening meal, and further increments (at weekly intervals) to either the A.M. or P.M. dose. In patients requiring insulin, reduction of insulin dosage is made as DBI-TD dosage is increased, until effective regulation is attained. (The acidosis-prone, insulin-dependent, unstable diabetic must be closely observed for "starvation" ketosis.) Sulfonylurea secondary failures usually respond to relatively low dosages of DBI-TD alone, or combined with reduced dose of sulfonylurea.

side effects: DBI-TD is usually well tolerated. Gastrointestinal reactions occur infrequently and are associated with higher dosage levels. They may include an unpleasant, metallic taste in the mouth, continuing to anorexia, nausea, and, less frequently, vomiting and diarrhea. They abate promptly upon reduction of dosage or temporary withdrawal. In case of vomiting, DBI-TD should be withdrawn immediately.

precautions: Particularly during the initial period of dosage adjustment, every precaution should be observed to avoid acidosis and coma or hypoglycemic reactions. Hypoglycemic reaction has been observed on rare occasions in the patient treated with insulin or a sulfonylurea in combination with DBI-TD. "Starvation" ketosis must be distinguished from "insulin-lack" ketosis which is accompanied by hyperglycemia and acidosis. A reduction in the dose of DBI-TD of 50 mg. per day (with a slight increase in insulin as required), and/or a liberalization in carbohydrate intake rapidly restores metabolic balance and eliminates the "starvation" ketosis. Do not give insulin without first checking blood and urine sugars.

caution and contraindication: As with any oral hypoglycemic agent, reasonable caution should be observed in severe pre-existing liver disease. The use of DBI-TD alone is not recommended in the acute complications of diabetes: acidosis, coma, infections, gangrene or surgery.

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General

Auxiliaries' Bizarre Bazaar

Through efforts of the Woman's auxiliaries of the Rock Island and Henry county medical societies, the American Education Fund has been enriched by $840.

Over 325 persons, many from out-of-town, attended the benefit luncheon-auction for the AMEF November 10 at the Plantation in Moline. Dr. George F. Lull, past-president, AMEF and president-elect of ISMS, was guest of honor and served with Mrs. Wendell Roller, Monmouth, president-elect of the state auxiliary, as auctioneer.

Gifts flowed in from every county in Illinois and from all states and were displayed with maps of their source. Items included potatoes from Idaho, pears from Oregon, canned corn from De Kalb County, watercolors, a convex republic mirror, hats, linens, knitted articles, jams, jellies, and baked goods. A fresh salmon from the state of Washington to serve 12 went for $25. A cut crystal decanter, a family heirloom, went on the block and was bought back by the family for $45.

At the luncheon Mrs. Thomas W. Carter, Moline, program chairman, presented to Dr. Lull a mosaic of Aesculapius made of chippings of cathedral window glass. It was the work of Sister Guala, head of the art department of Rosary College, and was presented "as an educator honoring another who has been dedicated to the education of future members of his profession."

The luncheon had an excellent press and radio and TV coverage.

Mrs. Carter conceived the affair and obtained items for sale. Auxiliary officers in attendance included Mrs. Richard E. Westland, Skokie, president of the state organization, Mr. William H. Kleinschmidt, East Moline, president for Rock Island County; Mrs. W. E. Morthland, Galva, represented the Fourth District, and Mrs. C. S. Costigan, Moline, state civil defense committee chairman. Mrs. Joseph E. Lundholm, Rockford, state chairman of the AMEF committee, represented Mrs. Harlan English, Danville, national president.

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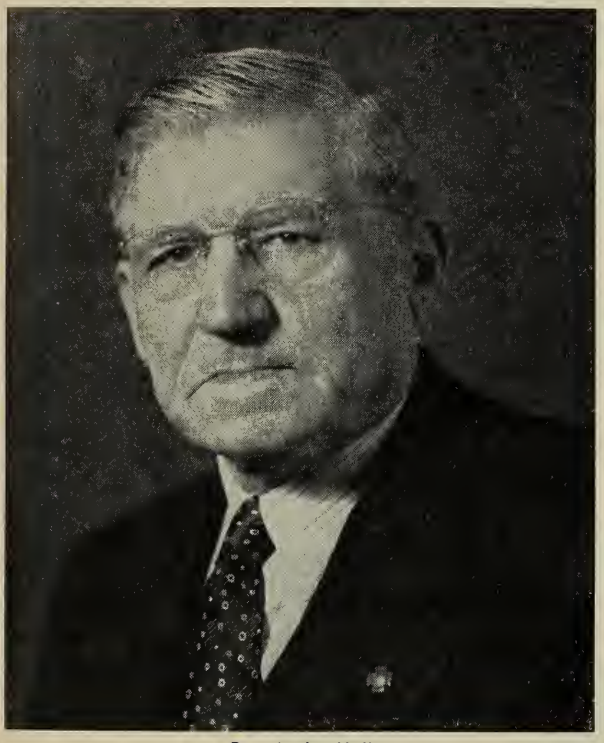


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Deaths

ANDY HALL*, beloved elder statesman of Illinois medicine, died November 25, aged 96. He leaves behind an immeasurable gift in good works and dedication to his profession.



Dr. Andy Hall

Dr. Hall was not only a citizen of medicine but an outstanding citizen of his community. From the time of his graduation from Northwestern University Medical School in 1890 until his death he practiced in Mt. Vernon and in 1897 was mayor of the town. For eight years he was president of the township's high school board and was the number one fan of the school's basketball team, never missing a game or tournament. The recently completed Andy Hall grade school in Mt. Vernon was named in his honor. In addition, he was past president of the Southern Illinois Medical Society and president of the Jefferson-Hamilton County Medical Society for eight years, and secretary for 15.

Andy Hall was a hard working member of the ISMS. He founded the Society's 50-Year Club in 1938 and remained its chairman. He was councilor from the Ninth District for 19 years and also served many years on the Society's Medico-Legal Committee. Dr. Hall presented more 50-Year Certificates than any other officer or councilor, and in 1959 he was honored by members of the club at their annual meeting luncheon with a billfold containing a gift of money and a huge scrapbook of congratulatory letters.

In 1949 he was named Outstanding GP of the Year by both the Illinois State Medical Society and the American Medical Association, and in 1946 Mt. Vernon honored him with its Outstanding and Distinguished Community Service award. The ISMS dedicated its annual meeting to him in 1950; during the past 50 years he had missed only two meetings, both because of military service.

From 1929 to 1932 he was director of the Illinois Department of Public Health, and during his tenure Illinois had the lowest mortality records up to that date. He waged a vigorous battle against trachoma and undulant fever and reduced greatly the threat from communicable diseases, notably smallpox and diphtheria. It was through his efforts that an Illinois law was passed making it compulsory to put silver nitrate in the eyes of newborn babies. He also is considered largely responsible for the formation of the State Sanitary Water Board to clean up stream pollution, and served as chairman.

His distinguished military record includes service as a major and surgeon in the Ninth Illinois Cavalry in the Spanish-American War, the U.S. Army Medical Corps in World War I, and chairmanship of the Selective Service Medical Board of Appeals for the 29th District of Illinois in World War II.

Dr. Hall had a proud family history. He was the descendent of Lyman Hall of Georgia, the third signer of the Declaration of Independence. His father, Hiron W., commanded an Illinois regiment in the Civil War and was a veteran of the Mexican War; Julia McLean Hall, his mother, was the daughter of the Illinois senator (1828) for whom McLean County was later named. His immediate family has produced nine physicians; there has not been a war in which Americans fought that did not include at least two or three Dr. Halls. His three physician sons are Marshall W., who practiced with his father; Andy Hall, Jr., St. Louis; and Wilfred F., retired major general in the Air Corps. Dr. Nelson Hall, a grandson, graduated from Annapolis and is now a junior at Northwestern University Medical School, and a

nephew, Dr. Charles W. Hall, practiced with Dr. Andy from 1903 to 1939.

Memberships included the American Legion and the Veterans of Foreign Wars.

Otto Balensiefer*, retired, Cedar Point, a graduate of the University of Illinois College of Medicine in 1904, died October 7, aged 85. Before retiring 10 years ago he had practiced in Cedar Point a half century. He was an emeritus member of the Illinois State Medical Society and belonged to its 50-Year Club. In World War I he served with the Army Medical Corps as a first lieutenant.

Francis Blonek*, Rock Island, a graduate of Charles University, Prague, Czechoslovakia, in 1914, died October 8, aged 70. He was a resident in obstetrics and gynecology at Prague University in 1919 and the following year did graduate work in Berlin and Vienna. From 1936-38 he was an instructor in roentgenology at Charles University Graduate School, Prague, and in 1939 came to America as an assistant in roentgenology at the Chicago University Clinics, where he remained two years.

Dr. Blonek became director of the department of roentgenology at St. Anthony's Hospital, Rock Island, in 1941 and left in 1943 to be consultant in roentgenology at the Rock Island County Tuberculosis Sanatorium. In 1946 he returned to St. Anthony's and again left in 1950 to open private practice in Rock Island.

Certified in roentgenology in 1948, he held fellowships in the American Association for Cancer Research and the American Medical Association. He was also a charter member of the Czechosolovak Society of Roentgenology and Radiology, and a member of the Radiological Society of North America.

Ernest E. Davis, Avon, a graduate of Northwestern University Medical School in 1900, died October 6, aged 86. Voted the Outstanding General Practitioner in Illinois by Fulton County and Doctor of the Year by the Illinois Medical Society in 1950, he was member of the ISMS 50-Year Club and its committee at the time of his death. In practice in Avon over 60 years, he was past president of the Fulton County Medical Society, of the Avon Village and School boards, and the board of Saunders Hospital. In addition, he was on the staff at Cottage Hospital, Galesburg.

Harford L. Drunasky*, Chicago, a graduate of the Chicago Medical School in 1928, died October 2, aged 59. A former Health Commissioner of Stickney Township, he was a member of the American Academy of General Practice and was on the staff of the Stickney Health Clinics until 1960.

Edward H. Dunn*, Elgin, a graduate of Rush Medical College in 1926, died October 18, aged 59. A past president of the Kane County Medical Society, he was on the staffs of Sherman and St. Joseph's hospitals in Elgin and belonged to the American College of Surgeons. In World War II he was a Navy commander.

Robert A. Elliott*, retired, Chicago, a graduate of Eclectic Medical College, Cincinnati, in 1905, died October 14, aged 80. Until his retirement two years ago he had practiced in Chicago 37 years.

Paul W. Herz*, Chicago, a graduate of the University of Illinois College of Medicine in 1952, died September 30, aged 35. He practiced in Elmwood Park and was a staff member of Oak Park, Walther Memorial, Mount Sinai, and Gottlieb Memorial hospitals.

Clair L. Ingalls, Wilmette, a graduate of Indiana University School of Medicine in 1926, died October 2, aged 59. The executive assistant to the American College of Surgeons, Dr. Ingalls had practiced in Rockingham, N.C., nine years before coming to the headquarters office in Chicago last January. In 1950 he was certified in surgery and in 1951 became a fellow of the College. He had been on the surgical staff of Richmond County Memorial Hospital, Rockingham, and was a surgical consultant at St. Joseph of Pines Hospital, South Pines, N.C., and a retired lieutenant colonel in the Army Medical Corps.

Wilber R. Landon*, retired, Chicago, a graduate of the Chicago Medical School in 1931, died July 22, aged 68.

William H. Lipman, retired, Chicago, a graduate of the University of Illinois College of Medicine in 1904, died August 26, aged 85. He had been medical director of Swift & Company until his retirement in 1942.

Bernard S. Maloy*, Chicago, a graduate of the University of Illinois College of Medicine in 1903, died June 29, aged 87. He was an emeritus member of the Illinois State Medical Society and a member of its 50-Year Club.

Roy F. Manning*, Westmont, a graduate of the University of Toronto Faculty of Medicine, Ontario, in 1923, died October 1, aged 63. Westmont was his place of practice since 1927. He was a member of the staff at Hinsdale Sanitarium and Hospital; memberships included the Lions Club of Westmont and the American Legion. During World War II he served with the Army Medical Corps.

Selim W. McArthur*, Elkhart, a graduate of the Rush Medical College in 1912, died August 2, aged 73. He was a former president of the Chicago Surgical Society and a past president of the medical board of St. Luke's Hospital, now Presbyterian-St. Luke's. In 1916 he became senior attending surgeon at St. Luke's and during World War I was a captain with a medical unit from the hospital in France. He also was a surgeon at the Chicago Orphan Asylum.

Francisco A. Rosete, Maywood, a graduate of the Loyola University School of Medicine in 1938, died August 16, aged 59. He had been a physician at Hines Hospital for the past 15 years and had been a major in the Army Medical Corps in World War II.

Thomas P. Saltiel*, Chicago, a graduate of the University of Illinois College of Medicine in 1924, died September 29, aged 63. He was a certified pediatrician and had practiced in Chicago over 30 years. From 1924 to 1926 he did graduate work in Vienna and Berlin and was an assistant professor of pediatrics at the University of Illinois Medical School. A member of the American Academy of Pediatrics and a former president of the Chicago Ethical Society, he also was an attending pediatrician at St. Joseph's Hospital.

Alvah L. Sawyer*, Elmhurst, a graduate of the University of Illinois College of Medicine in 1913, died October 4, aged 80. Formerly on the staff of Cook County Bureau of Public Welfare, he was a staff member of West Suburban Hospital and had been assistant professor of medicine at the University of Illinois College of Medicine from 1921 to 1937.

Horatio C. Wood*, Peoria, a graduate of the University of Pennsylvania School of Medicine in 1938, died September 5, aged 57. He was president of the Peoria Mental Hygiene Clinic in 1959-60 and medical director of the Michell Sanatorium in Peoria from 1946-48. He was certified in psychiatry in 1947 and had been a consulting psychiatrist at Peoria State Hospital since 1957 and on the active staff of Peoria Methodist Hospital since 1947. In 1947 he served as clinical assistant in the outpatient department of Northwestern University and since 1951 had been an instructor in psychiatry at Bradley University, Palatine.

Before coming to Illinois, he had been a staff physician at the Pennsylvania Hospital for Mental and Nervous Disorders from 1939-40 and an instructor in psychiatry at the University of Pennsylvania for the next four years. During that time he also was a consulting psychiatrist at Norwalk General Hospital and from 1940-43 a staff physician at Silver Hill Foundation, both in Connecticut.

Dr. Wood was a member of the American Psychiatric Association and the American Association for Advancement of Science, and during World War II was a major in the U.S. Army Medical Corps.

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